Medicines Management Workbook

For all clinical staff that deal with medicines on a regular basis

Please ensure you read the workbook thoroughly and complete the assessment at the end
Introduction

Welcome to the Medicines Management workbook. It is designed to refresh your awareness of the processes surrounding the use and storage of medicines and the key issues that relate to safe prescribing and administration.

Please read through the book and then complete the questions at the back. The completed questions should be returned to the Pharmacy Department for review. Please also sign the declaration to acknowledge that you have read and understood your responsibilities for medicines management.

Learning Outcomes

After reading this workbook you should be able to:

- Describe how to obtain medicines and where to get advice for any medication queries or concerns
- Explain the principles and importance of the safe and secure handling of medicines
- State the implications of omitted doses and how to avoid them
- List 5 high risk medicines and the actions needed to ensure they are used safely
- Describe the common causes of medication errors, consider how medication errors can be avoided and what action to take following incidents

THE PHARMACY SERVICE

Pharmacy Core Hours
Monday to Friday 9am to 5pm (extension 85701)
Saturday 10am to 1pm
Weekend Discharges 9am to 3pm

Emergency Duty Service
The On-call Pharmacist is available out of hours through switchboard for urgent medication queries.

Clinical Service
Most wards will have a regular Pharmacist visit on a pre-arranged schedule. They are also contactable by bleep or mobile phone weekdays during pharmacy core hours. On Saturday morning a pharmacist will provide a clinical service to Ward 1 only. They will screen the drug charts and the discharge TTOs and provide help and advice on any query or concern on the prescribing and use of medicines. They will also reconcile patients’ medication on admission and supply medicines.

Some wards will additionally have a Pharmacy Technician; they will obtain medication histories, supply medicines and deal with any supply or stock queries.
Dispensary

You can track the progress of your TTOs on the “Tracker” system from your ward PC. Each ward has its own password to access this.

OBTAINING SUPPLIES

During pharmacy core hours all requests for medication should be made to the pharmacy department. If the request is urgent explain to the pharmacy team so the supply can be made promptly.

Inpatients

Use the ward communication book (see below) to notify your Pharmacy team which patients are new or need supplies of medicines (newly-prescribed or non-stock items). Contact your ward Pharmacist or send the chart and ward communication book to Pharmacy for supplies if the Pharmacist has left the ward and the medicine is unavailable from stock.

For medication supply out of hours and not available on any other ward the Pharmacy Emergency Cupboard (PEC) can be accessed through the Duty Nurse Manager.

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[Image of Pharmacy Order Book]

Due to audit purposes do not detach sheet from book

Milton Keynes Hospital Pharmacy Order Book

- This sheet is for ordering non-urgent and non-stock items.
- Ward stock items should be ordered from pharmacy distribution via the green “stock item” slips, which can be sent to pharmacy using the PCD system, messenger service or put into the pharmacy bags.
- Continuous or regular medication will only be ordered after patient has been in for 48 hours where applicable.
- This sheet will be checked daily on weekdays and whole book should be sent to the Pharmacy department on Saturdays along with patients’ medicine charts.

For urgent items between 9am and 5pm weekdays, please call your ward pharmacist or medicines management technician.

<table>
<thead>
<tr>
<th>Ward Use Date</th>
<th>Bay/Bed No.</th>
<th>Patients Name</th>
<th>Re-Written chart (tick)</th>
<th>New pt (tick)</th>
<th>Medication required, Forms/Strengths</th>
<th>Ordered (tick)</th>
<th>Not supplied (reason)</th>
<th>Pharmacy Use</th>
<th>Tech/Pharm Name (init)</th>
<th>Sheet checked (time &amp; date)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Comments
Stock
Most wards have a weekly top-up of stock items by Pharmacy Assistants. Alternatively send a green stock request slip to Pharmacy between top-up days.

CONTROLLED DRUGS

Ordering
Send the completed CD requisition book to Pharmacy (Monday to Friday). Contact pharmacy at the weekend for urgent CDs only.
To comply with the law the requisition must include the drug name, form, strength and quantity of the item.
Orders for high dose Diamorphine or Morphine ie. 20mg and above must be countersigned by a Pharmacist.

Receipt
On return of the CDs to the ward a signature is needed from the staff nurse for receipt before the red bag can be left. The contents must be checked and CD requisition book signed. The drugs must be stored securely in the CD cupboard and entered in the CD record book. The requisition and record books must also be stored in the CD cupboard.
**Storage**
Different strengths of the same preparation e.g. Morphine must be stored on different shelves. (NPSA)
Stock balances must be checked once a week (or once a day on Ward 6 – Critical Care and Neonatal Unit - NNU) and a full check every three months by the Pharmacist and registered nurse.

**Administration**
The dose must be checked by a second registered nurse prior to administration and an entry made in the CD record book.

**Disposal**
Disposal of partially used ampoules must be witnessed and an entry made in the CD record book.
Any other used or expired CDs must be signed out of the register by a registered nurse and Pharmacist/Pharmacy technician and returned to pharmacy.

**MEDICINES INFORMATION**
We provide a service for healthcare professionals and patients to deal with all medicine related queries.

The team can be contracted on:

*Extension 85738 (for M.I. queries)*
*Email: Medicines.information@mkuh.nhs.uk*
*The Patient enquiry line can be accessed on 01908 995733*

**FORMULARY MANAGEMENT**
The Trust has a Prescribing Advisory Group (MKPAG) and a joint formulary with Milton Keynes Clinical Commissioning Group (CCG).

To request an addition to the formulary an application form needs to be completed and submitted to the group as does the use of a medicine “off label” or an unlicensed medicine.

*Extension 85731 (for formulary enquiries)*
*The E-formulary can be found at:*
http://www.formularymk.nhs.uk

Drugs included in the formulary are listed according to BNF class and are colour coded as follows:

**4. Central Nervous System**

<table>
<thead>
<tr>
<th>First line drugs</th>
<th>Second line drugs</th>
<th>Specialist drugs</th>
<th>Secondary care drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended in both primary and secondary care</td>
<td>Alternatives (often in specific conditions) in both primary and secondary care;</td>
<td>Where a specialist input is needed (see introduction for definition)</td>
<td>Prescribing principally within secondary care only</td>
</tr>
</tbody>
</table>
Controlled drugs are highlighted with the symbol **CD**. Full details of the regulations appear in the BNF.

**GUIDELINES FOR INPATIENT PRESCRIBING**

Prescriptions must clearly state:

- Patient’s name, hospital number and D.O.B.
- The consultant and ward
- The patient’s weight

Always:

- Use black ink, BLOCK CAPITALS, approved names, metric doses and write “units” and “micrograms” in FULL (NPSA guidelines)
- Sign and date ALL prescriptions (legal requirement)
- Add bleep number
- Clearly indicate the administration times for regular medicines
- Do NOT alter existing entries on drug charts, always make a new entry to maintain the audit trail
- Cross out, date and initial all discontinued medicines
- Record Drug allergies, including NKDA on all drug charts

*Further information can be found in Medicines Management Policy on the intranet*

**NEW ADULT INPATIENT DRUG CHART**

This was first launched in July 2014 with the aim to improve safety.

There are separate anticoagulant and antibiotic sections to facilitate safe prescribing and administration

**Anticoagulant Section-Page 4**

- VTE prophylaxis assessment verification
- VTE prophylaxis
- Anti-embolic stockings

Nurses should sign at each drug round to confirm the stockings are being worn and are fitted correctly, also sign each day to confirm a daily inspection and leg wash has taken place.

- Initiating warfarin-dose guide
Anticoagulation Section - Page 5
Use this section for all therapeutic anticoagulation prescribing for the following:

- Warfarin
- Low Molecular Weight Heparin LMWH (Dalteparin)
- Subcutaneous Unfractionated Heparin
- Newer Oral Anti-Coagulants (NOACs) in line with local prescribing guidelines.

All infusions of IV Heparin are prescribed on a supplementary chart.

IV Antibiotic section - Pages 6
After 48 hours prescribers should review their suitability and sign to confirm a review has taken place.
NEVER omit antibiotic therapy if the review has not been signed.

Long term prophylactic courses may be prescribed in the regular section e.g. prevention of neutropenic sepsis and a reference made on the IV antibiotic page to the regular section where prescribed.

Oral Antibiotic section - Page 7
Prescribers should clinically review the need to continue after 5 days and re-prescribe if still needed.
Administration of a new antibiotic is signed for starting from day 1 column.

GUIDELINES FOR EDS TTO PRESCRIBING

EDS is accessed via the Intranet “Clinical Tools” tab.

Controlled drugs need an additional paper form completing to comply with Prescription Requirements which are the law. The form is accessed by clicking on the link (red writing). The form must be printed and handwritten by the prescriber to include:
• Name and address of the patient
• The form and strength of the preparation
• The dose
• The total quantity (in words and figures) of the preparation
• Signed and dated

Dosette boxes
If the patient needs a Dosette box on discharge a minimum of 1 working days’ notice is needed in advance.

MEDICINES RECONCILIATION AND OPTIMISATION

What is the difference?

Medicines Reconciliation
Is the process of identifying an accurate list of a person’s current medicines and comparing them with the current list in use, recognising any discrepancies and documenting any changes, thereby resulting in a complete list of medicines accurately communicated. The process of reconciling medicines should be carried out within 24 hours of admission or sooner if clinically necessary.

Medicines Optimisation
Defined as a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines.
(NICE guidance 2015)

Discrepancies on Admission
These can be either intentional or unintentional. Some medication may not have prescribed for a reason e.g. an NSAID in the case of a gastric bleed. Unintentional discrepancies should be brought to the attention of the prescriber for review where appropriate.

Patient A was admitted via the emergency department following a history of falls over the last week. The patients regular diuretic was not prescribed.

Patient B was admitted via the emergency department with a history of shortness of breath. A chest infection was diagnoses. The patients regular inhalers were not prescribed.

Patient C was admitted via the emergency department having collapsed at home. The patient complained of headache and dizziness. The patients DHx includes Anti-Parkinson’s medicines which have not been prescribed.

Patient D was admitted via the emergency department complaining of abdominal pain. On questioning they described two episodes of vomiting which had been blood stained. The patients regular diclofenac was not prescribed.
Finding out about a Patient’s Medicine

What information is needed?

Anything taken regularly, all when required medicines, any previous drug history, inhalers, creams, eye preparations, Over the Counter (OTC) medicines, herbal remedies, use of MDS (monitored dosage systems), relevant social history and the allergy status

Sources of Information

The patient, a relative or carer, Patient’s own Drugs (PODs), EDS (Electronic discharge system) letter, Dr, nursing home administration chart, GP letters, GP surgery, EDM, Summary care records (SCR), Community Pharmacist

Using Patient’s Own Medicines

It is acceptable to use Patient’s own strips on admission providing they are stored in bedside medicines lockers and have been assessed as suitable following the Trust procedure for use of Patients’ own drugs until the Pharmacy team have completed the medicines reconciliation.
**HOW TO CHECK IF PATIENT'S OWN MEDICINES (PODs) ARE SUITABLE TO USE UNTIL PHARMACY CAN FULLY ASSESS THEM**

1. **Can you identify the POD as belonging to the patient?**
   - Ask the patient and check the name on POD label
   - **NO**
   - **YES**

2. **Does the label have clear relevant instructions?**
   - Clean, no handwritten additions or crossing out
   - **NO**
   - **YES**

3. **Does it look OK?**
   - In a suitable container, clean and dry, no signs of deterioration, can you identify the contents?
   - **NO**
   - **YES**

4. **Is it still in date?**
   - Check the expiry date or if there isn't one was it dispensed less than 6 months ago? If eye drops, were they opened less than 4 weeks ago?
   - **NO**
   - **YES**

5. **Check the contents of the POD**
   - Do they all look the same?
   - If a liquid does it look free from foreign particles?
   - Make sure the contents match the label
   - **NO**
   - **YES**

**POD suitable to use**

**DO NOT USE**
Self -Administration of Medicines (SAM)
Combining SAM with the use of PODs enables patients to continue to use medicines they are familiar with during their inpatient stay. The benefit of SAM is that patients maintain control of their medicines. There are 3 levels.

SAM levels of Supervision:
- Level 1- Full Supervision (Red)
- Level 2- Close Supervision (Yellow)
- Level 3- Full patient administration (Green)

The patient must be assessed to ensure that they are able to safely administer their own medicine. The policy for SAM can be found on the intranet.

SAFE AND SECURE HANDLING OF MEDICINES

The Trust has a duty to comply with the standards set out in the document-

“The Safe and Secure Handling of Medicines: A team Approach”
(Duthie Report 1988, revised March 2005).

The Care Quality Commission (CQC) expects to see evidence of compliance with this document.

This includes standards for the following:

- The storage of medicines e.g. fridge temperature monitoring
- The disposal and return of medicines
- Controlled Drugs
- The security of stationary (including blank drug charts and FP10 /out-patient prescriptions and the ordering forms associated with them)

The Pharmacy Medicines Safety team complete regular audits to check compliance of the standards on all wards and departments.

Issues that have identified from these audits are:
- Stock medicines not stored correctly in their original boxes
- Fluids containing Potassium not separated from others
- Refrigerators not locked
- Medicine trollies not locked or immobilised
- Treatment rooms and Fridges not temperature monitored
- Expired/unwanted medicines not stored securely

OMITTED DOSES

Harm from Omitted Doses

Medicine doses are sometimes omitted or delayed in hospital for various reasons. This may not seem serious but for some critical medicines or conditions e.g. Sepsis, this omission or delay can cause serious harm or even death.
From September 2006 to June 2009 the NPSA received 21,383 reports of patient safety incidents relating to omitted or delayed medicines

- 68 resulted in severe harm
- 27 resulted in death

In February 2010 the NPSA issued a Rapid Response Alert to reduce harm from omitted or delayed medicines. In November 2014 a local audit on missed doses was conducted over a 24 hour period which highlighted the following concerns:

- There were high rates of omitted doses throughout the Trust
- Overall only 87% of the doses of critical medicines were administered
- High percentages (up to 92%) of missed doses had no reason recorded for the omission i.e. the box was blank

Reducing the harm

So how can we reduce harm resulting from omitted doses?

Use the Critical medicines list on Page 3 of the drug chart to highlight and check for any medicines that MUST be given on time.

- Ensure they are given on time
- Keep the records accurate on the drug chart
- Either sign for dose administered or use the “medicines not administered” codes to record the reason it hasn't been given e.g. 3 for patient refused
- Pharmacy will audit monthly and use the data to review the stock lists along with the Emergency Cupboard stock list
- Ensure the patient’s locker has been checked and the Pharmacy delivery bags have been opened to reduce the number of omitted doses.
- Check the master stock lists on the intranet for a ward which stocks the medicine needed or if out of hours obtain from the Pharmacy Emergency Cupboard through the Duty Nurse Manager or contact the on call Pharmacist. Do not record 5 ‘drug not available’.

Examples of Critical Medicines

<table>
<thead>
<tr>
<th>Insulin</th>
<th>Opiates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Parkinsonian Agents</td>
<td>Anti-epileptics</td>
</tr>
<tr>
<td>Antimicrobials</td>
<td>Cytotoxics/Chemotherapy</td>
</tr>
<tr>
<td>Antiretrovirals</td>
<td>Oral Hypoglycaemic Agents</td>
</tr>
<tr>
<td>Immunosuppressants</td>
<td>Bronchodilators</td>
</tr>
<tr>
<td>Glucose/Gucagon</td>
<td>Corticosteroids</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td></td>
</tr>
</tbody>
</table>
MEDICATION INCIDENTS AND ERRORS

What is the difference?

Patient Safety Incident (PSI)

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. (NRLS)

Medication Error

Medication errors are any PSIs where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines. (NHS England)

The most frequently reported types of medication incidents involve:

- Wrong dose
- Omitted or delayed doses
- Wrong medicine

Why should we be concerned?

Medicines are high risk products and the following are examples medication incidents reported to the NPSA:

Wrong medication

A patient was prescribed prednisolone and clarithromycin for CAP by their GP. The patient took the medicines prescribed and collapsed. They were brought into A&E and were bradycardic and hypotensive. On examination of the PODs a box of propranolol 40mg labelled 'Take 8 tablets once daily for 5 days’ was found. The patient should have received prednisolone. The patient had taken 320mg of propranolol as a single dose.

Known allergy

A patient was given trimethoprim for UTI. Shortly afterwards they collapsed and arrested. The prescription stated that the patient was allergic to co-trimoxazole (which contains trimethoprim). The patient was admitted with a possible/probable diagnosis of anaphylactic shock.

Errors lead to a variety of problems ranging from minor discomfort to substantial morbidity that may prolong hospitalisation or even lead to death.

Research evidence indicates the following medication error rates:

- Prescribing error rate in hospital, 7% of prescription items
- Dispensing error rate in hospitals, 0.02 to 2.7% of dispensed items
- Administration errors in hospital, 3 to 8% of administered items
  
  (NHS England 2014)

The NHS wastes at least £1bn a year on preventable errors, many of which are related to improper use of medication.
HIGHEST RISK MEDICINES
What are the highest risk medicines and what are the risks?

1. Antimicrobials
   What are the risks?
   - Errors can be made in the preparation process of IV antimicrobials
   - Antibiotic resistance is high up on the international agenda

   How can the risks be minimised:
   - Prescribe in accordance with the Trust Antimicrobial Policy
   - “Start Smart….then Focus” initiative to ensure the appropriate use of Antibiotics
   - Remember: Intravenous to Oral Switch
   - Remember: Surgical Prophylaxis

   ![Antimicrobial stewardship diagram]

2. Opioid Analgesics
   What are the risks?
   - Opiate toxicity, causing respiratory depression and hypotension

   How risks can be minimised:
   - Confirm if the patient has had recent opioid doses, which formulation and the frequency of administration
   - Take particular care with opioid naïve patients
   - Ensure any dose increase is safe for the patient
   - Double check the formulation prescribed e.g. standard-release verses modified release Morphine preparations
   - Ensure Naloxone injection (antidote) is available on the ward
3. Anticoagulants

What are the risks?
- Bleeding

How can this be minimised?

Warfarin

- Counsel the patient on initiation of therapy and use the Yellow book
- Regular INR checks

Low Molecular Weight Heparins & Unfractionated Heparin

- Never abbreviate units to u or iu
- Dalteparin: Use weight based treatment doses
- Unfractionated Heparin for prophylaxis if there is renal impairment

Direct Oral Anticoagulants (DOACs)

- Formerly known as New Oral Anticoagulants (NOACs)
- Follow the MKPAG guidelines; there is a limited place in therapy due to the bleeding risks and difficulty with reversal

4. Oral Chemotherapy

What are the risks?

- Bone marrow suppression

How can this risk be minimised:

- ALL anti-cancer medicines should be STOPPED on admission to hospital, until reviewed by an Oncologist or Haematologist
- Prescribing of cytotoxic drugs is restricted to consultants, registrars or non-medical prescribers with specialist training and competence in this area
- See section 8.1 of the BNF for “Oral Anti-cancer medicines” for drugs included in this list

Examples can include: Capecitabine, Etoposide, Temozolomide and Imatinib
5. Insulin

What are the risks?

- Maladministration
- errors due to inappropriate abbreviation of units e.g. 5u may be misinterpreted as 50units

How can the risks be minimised?

- Always prescribe using the approved and brand names e.g. Insulin Glargine (Lantus) Insulin Aspart (Novorapid)
- Always use Insulin syringes or pen devices to administer Insulin and never abbreviate units to u or iu

MEDICINE RELATED PATIENT SAFETY ALERTS

Previously all NHS patient safety alerts were issued by the NPSA; these responsibilities have now been transferred to NHS England. Many of these alerts cover the high risk medicines mentioned and information for these can be found on the following website:

[https://www.england.nhs.uk/ourwork/patientsafety/psa/](https://www.england.nhs.uk/ourwork/patientsafety/psa/)

NHS NEVER EVENTS

These are defined as “Serious incidents that are wholly preventable because guidance or safety recommendations providing strong, systemic, protective barriers are available at a national level and should have been implemented”.

The Never Events list is updated by NHS England. When an event occurs it portrays a very negative impression of an organisation.

Between 2012 and 2014 there were 667 reports of “Never Event” occurrence.

NHS Never Events (medication)

Many of these include high risk medicines *Examples include:*

- Miss selection of a strong potassium containing solution
- The wrong route of administration
- Overdosing of Insulin due to abbreviations or incorrect device
- Overdosing of Methotrexate for non-cancer treatment
- Miss selection of high strength Midazolam during conscious sedation
Types of Medication Errors

<table>
<thead>
<tr>
<th>Prescribing</th>
<th>Dispensing</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate drug choice</td>
<td>Inappropriate labelling</td>
<td>Given to wrong patient</td>
</tr>
<tr>
<td>Transcription errors</td>
<td>Calculation problems</td>
<td>Given by wrong route or rate</td>
</tr>
<tr>
<td>Inappropriate monitoring</td>
<td>Providing inadequate information</td>
<td>Omitted dose</td>
</tr>
</tbody>
</table>

Causes of Medication Errors

- Lack of knowledge of the medicine
- Inadequate monitoring
- Preparation Errors
- Environmental factors
- Poor handwriting
- Staff workload and fatigue
- Inexperienced and inadequately trained staff

INCIDENT REPORTING

Why report?

- So all of us can continue to learn and improve
- To prevent the error happening again

We all have a duty to act when we believe a patient’s safety is at risk. The Trust uses the IT based reporting system “Datix”. Following the investigation and approval the incidents are reported externally to the National Reporting and Learning System (NRLS). The collation of incident data at a national level provides a clearer picture of the patient safety issues that need to be prioritised across the NHS. (It is best practice to report any incidents verbally to your line manager before reporting the incident on Datix)
Questions

1) Answer TRUE or FALSE for the following statements. On inpatient prescription charts prescribers

- Can use abbreviations like MCG and IU if written clearly □ True □ False
- Must legally include the date and be signed by the prescriber □ True □ False
- Must include the name and strength of medication □ True □ False
- Can be amended as long as the prescriber signs next to the amendment □ True □ False
- Must include the prescribers bleep □ True □ False

2) Read the following scenario and decide whether it is an ‘intentional’ or ‘unintentional’ discrepancy

Mrs A is admitted to AMU complaining of severe headache. When asked about her medication she tells the doctor that she has no tablets prescribed regularly by her GP. The following day during a conversation with the pharmacist Mrs A says that she has some inhalers at home that she uses very infrequently which she forgot about when the doctor asked her about her medicines the previous day.

□ Intentional
□ Unintentional

3) Read the following scenario and decide whether it is an ‘intentional’ or ‘unintentional’ discrepancy

Mr J is admitted to A&E complaining of abdominal pain. When questioned he tells the doctor that he had vomited up a small amount of blood on two occasions earlier in the day. Amongst his medication Mr J tells the doctor that he usually takes Diclofenac 50mg TDS for back pain. The doctor does not prescribe this medication on the prescription chart.

□ Intentional
□ Unintentional

4) Within what time should Medicines Reconciliation be carried out?

□ 12 hours
□ 24 hours
□ 48 hours
□ 72 hours
□ Any time before discharge

5) Accurate sources for obtaining a medication history include: (Please tick all that apply)

□ The patient
□ The patient’s own medication in labelled boxes
□ Loose medication strips
□ EDM
□ GP letter
□ Hand written medication list
6) Please match the correct description how a patient would be supervised taking their medication to the three different levels of the SAM (Self Administration of Medicines) Scheme:

Level 1 (Red)  □ Full patient administration □ Full supervision □ Close supervision
Level 2 (Yellow)  □ Full patient administration □ Full supervision □ Close supervision
Level 3 (Green)  □ Full patient administration □ Full supervision □ Close supervision

7) At what point should IV antibiotics be reviewed:

□ After 3 doses
□ After 48 hours
□ After 5 days
□ Whenever the patient feels better
□ Patients should continue on IV antibiotics until discharge

8) If you were presented with each of the products below as a Patient’s Own Medication, decide whether you would ‘use’ or ‘not use’ each of them.

- **Pharmacy Made Dosette Box**
  - □ Use
  - □ Not use

- **Labelled Insulin Pen**
  - □ Use
  - □ Not use

- **Labelled Blister Pack**
  - □ Use
  - □ Not use

- **Loose Strips**
  - □ Use
  - □ Not use
9) From September 2006 to June 2009 the NPSA received 21,383 reports of patient safety incidents relating to delayed and omitted doses. How many resulted in death?

□ 5982
□ 1039
□ 271
□ 62
□ 27

10) If a patient is prescribed something that they have not brought into hospital with them and it is not stocked on the ward, which of the following is NOT an appropriate course of action? (Please tick all that apply)

□ Take it from another patient that has the same medication
□ Borrow the item from another ward
□ Ring your ward pharmacist or on-call pharmacist out of hours for supply
□ Annotate the chart as '5' (drug not available) and put it on the order form for tomorrow
□ Ask the site manager to get the item from the Pharmacy Emergency Cupboard (if it is kept there)

11) Which of the medicines listed below are included in the Critical Medicines List in the Inpatient drug chart? (Please tick all that apply)

□ Insulin
□ Antimicrobial
□ Antihypertensives
□ Chemotherapy
□ Antidepressants

12) If you witness a medication error involving a patient, what should you do? (Please tick all that apply)

□ Do nothing – you don’t want to get anyone in trouble and it wasn’t actually your error
□ Speak to the your other colleagues about the incident so that they can keep an eye on the person(s) involved
□ Speak to your line manager about the incident and reflect on your part in the incident
□ Report the incident on Datix so that everyone can learn from the error and improvements can be made
□ Speak to the other member(s) of staff involved and decide who will take the blame for the error before reporting on Datix
□ Keep the patient or the patient’s family /carer where appropriate informed
13) Which one of these could increase the risk of medication errors happening? (Please tick all that apply)

- □ Lack of knowledge of the medication
- □ Environmental factor e.g. noisy environment, cluttered workspace
- □ Other members of staff not doing their job fully/competently
- □ Heavy staff workload and fatigue
- □ Inexperienced and inadequately trained staff

14) How often can the following medicines be administered safely? (Please tick all that apply)

<table>
<thead>
<tr>
<th>Medicine</th>
<th>4-6 hourly</th>
<th>12 hourly</th>
<th>24 hourly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zomorph MR 30mg capsule</td>
<td></td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Sevredol 10mg tablets</td>
<td></td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Adalat LA (nifedipine LA) 20mg tablets</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>OxyNorm 5mg capsules</td>
<td></td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Nitrofurantoin MR 100mg capsules</td>
<td></td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

15) What is missing from this tramadol prescription? (Please write answer on next page)

Mr A Patient
123456
A Ward
1 The Street, Milton Keynes

Drugs Form for TTOs:

Tramadol
STRENGTH 50mg

100mg four times a day when required
I confirm that I have completed the Medicines Management Training Workbook and understand my responsibilities in relation to medicines management.

Name (print):  
Signature:  
Job Title:  
Ward/Department:  
Date Completed:  

Office Use  
Results  
Pass  
Fail  

Please write the answer for question 15 here:

Please return the assessment paper only to:

Pharmacy Education & Training Manager  
Pharmacy Department