



ELIXIR MEDICS
Prioritising your Mental Health

Medicines Management Policy

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1. Introduction

1.1. Guidance statement

This purpose of this policy is to ensure that there is an effective governance framework at Elixir Medics that supports safe systems for the administration, prescribing and disposal of all medicines.

Effective medicines management promotes safe and cost-effective prescribing, outlines legal requirements and reduces the risk of medicines related incidents. This policy is to be read in conjunction with the hyperlinked referenced legislation and guidance.

1.2. Status

The organisation will aim to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](#). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

2. Prescription management

2.1. Prescription security

This organisation will adhere to the NHS Counter Fraud Authority (NHS CFA) guidance on the [management and control of prescription forms](#) while meeting the expectations detailed in the Care Quality Commission (CQC) [GP Mythbuster 23: Security of blank prescription forms](#). This [NHS CFA aide-mémoire](#) provides useful advice for the prescription management.

A template for a prescription log can be found at [Annex A](#).



2.2. Ordering of prescriptions

FP10 prescriptions for this organisation are ordered through Xerox (UK) Ltd. by the registered individual. Orders detailed information is available on the NHS Business Services Authority (NHSBSA) [Prescription forms webpage](#).

2.3. Delivery and storage of prescriptions

Section 4 of the [Management and control of prescription forms](#) outlines the process to be followed when receiving prescription forms. This process is illustrated in diagrammatic form at [Annex B](#).

2.4. Issuing prescription stock

NHS CFA stipulates that this organisation must maintain clear and unambiguous records on prescription form stock and distribution. This organisation will achieve this by using the template at [Annex A](#). Note, at this organisation, this will be retained in e-format.

2.5. Security of prescriptions in the community

When travelling, making home visits or undertaking visits to care homes, prescribers are to adhere to the guidance detailed in the [NHS CFA Aide-mémoire for prescribers](#).

2.6. Locums and prescription forms

This organisation will use the prescription log template at [Annex A](#) to record the prescription issued to locums. Unused prescriptions will be returned to the nominated individual at the end of the session.

2.7. Disposal of prescription forms

The process for the destruction and disposal of prescription forms can be found at section 4.23 of the NHS CFA [Management and control of prescription forms](#) guidance document.

2.8. Reporting prescription form incidents

The process for dealing with either the loss or theft of prescription forms is detailed at [Annex C](#). Note, this incident response table was sourced from NHS CFA.

2.9. Prescription form lost by patient

Should a patient report they have lost a prescription, a risk assessment is to be undertaken prior to a replacement being issued. This will ensure the reported loss is genuine and not an attempt to commit prescription fraud. If the prescription is for a controlled drug, then the Controlled Drugs Accountable Officer (CDAO) is to be informed to make certain the medication is dispensed to the correct patient without incident.

A risk assessment template can be found at [Annex D](#).

3. Accountability

3.1. Clinical staff

All clinicians authorised to prescribe within this organisation are aware that it is the clinician who signs the prescription who will be held accountable should an error or incident occur. Prescriptions issued on the recommendation of a non-prescriber, i.e., a nurse or allied healthcare professional, remain the responsibility of the named, authorised prescriber.

Clinicians must only prescribe medicines, devices or dressings when they are satisfied that they have sufficient knowledge of the patient's health and that they are content that the prescription is fully justified.

3.2. Guidance

All authorised prescribers are to follow the guidance provided in the [British National Formulary](#) (BNF) and [National Institute for Health and Care Excellence](#) (NICE) guidance. If prescribers have any uncertainty regarding any element of prescribing, they are to seek guidance from suitably experienced colleagues, a pharmacist or a prescribing adviser.

3.3. Non-medical prescribing

A range of non-medical healthcare professionals can prescribe medicines for patients as either independent or supplementary prescribers. NICE provides [detailed guidance](#) on non-medical prescribing, explaining that supplementary prescribing is a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed clinical management plan for an individual patient with that patient's agreement.

The NICE guidance covers nurse, pharmacist, physiotherapist and paramedic independent prescribers.

Community Pharmacy England (CPE) advises different types of prescribers hold different prescribing rights. This guidance explains [who can prescribe what](#).



It is the responsibility of prescribing lead at this organisation to ensure that independent prescribers have the necessary skills and knowledge to carry out their role effectively.

3.4. Generic prescribing

[Specialist Pharmacy Service](#) (SPS) advises that prescribing medicines by generic name is generally preferred. This is because it reduces risk, enables quicker medicine supply and offers value for money. At this organisation, prescribers are to prescribe by generic name unless circumstances dictate otherwise. If a prescriber is uncertain, they are to seek guidance from the organisation's prescribing lead.

3.5. Prescribing unlicensed medicines

The [GMC](#) defines unlicensed medicines as medicines that are used outside the terms of their UK licence or that have no licence for use in the UK. Unlicensed medicines are commonly used in some areas of medicine such as in paediatrics, psychiatry and palliative care.

If a clinician intends to prescribe unlicensed medicines when it is not routine or if there are suitably licensed alternatives available, this should be explained to the patient along with the reasons for doing so.

3.6. Prescribing covert medication

Covert administration of medicines should be a last resort. Reasonable efforts must be made to give medicines in the normal manner. Alternative methods of administration should also be considered. See the CQC [Covert administration of medicines guidance](#) for further information.

3.7. Repeat prescribing

Prescribers at this organisation are to adhere to the [GMC repeat prescribing guidance](#) at all times.

4. Prescribing processes and systems

4.1. Recording prescriptions

All prescriptions (when practically possible) are issued and printed electronically using the electronic clinical system. Handwritten routine prescriptions are not normally written at this organisation unless circumstances dictate otherwise, i.e., a power failure.



Prescribers must ensure prescribed medication is recorded as acute, repeat or current on the clinical system. It is imperative that accurate records are always maintained and prescribers are to follow the GMC [Good practice in prescribing and managing medicines and devices](#).

Clinicians undertaking home visits are to take printed patient summaries with them that include details of patient medications and known allergies. The clinician can use the summary to record notes, particularly details of handwritten prescriptions, the information from which can be added to the patient's healthcare record on return to the organisation.

4.2. Electronic Prescription Service

The [Electronic Prescription Service](#) (EPS) enables prescriptions to be sent to pharmacies from this organisation electronically, making the prescribing and dispensing process more efficient for staff and patients alike. Patients can choose the pharmacy where they would like their prescription to be sent; this is referred to as "nomination" and can be set, changed or cancelled as required.

4.3. Electronic Repeat Dispensing

[Electronic Repeat Dispensing](#) (e-RD) is a process that allows a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to hand sign authorised repeat prescriptions each time. This allows the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. The prescriptions are then available for dispensing at the specified interval by a patient's nominated dispenser.

For detailed guidance see NHS England's [Electronic Repeat Dispensing - Guidance](#)

A range of e-RD resources specifically for GP practices are available from [NHS Business Services Authority](#).

4.4. Urgent requests

Requests for urgent repeat prescriptions (less than 48 hours) are to be reviewed to ascertain if the medication is needed that same day. If this is deemed to be the case, the request is to be processed without delay. The patient is to be advised to call back to collect their prescription. For patients who repeatedly request urgent repeats, the Practice Manager is to be informed.

4.5. Emergency prescriptions

There are numerous ways for patients to request emergency prescriptions. Usually, the patient will contact this organisation. However, they can also use the 111 online emergency prescription service or visit a pharmacy or urgent treatment centre. Additional information is available from [NHS England – Emergency prescriptions](#).



4.6. Private prescriptions

The [BMA](#) advises that if a clinician receives a letter from a private consultation advising medication be prescribed, then it may be appropriate for a prescription to be issued on a FP10 if the clinician agrees with the advice. The prescriber assumes clinical responsibility for monitoring, so they must ensure they are able to accept this responsibility.

Should a clinician be asked by a private consultant/secondary care to prescribe specialist medication, non-formulary, red, grey or blacklisted medications then it may be reasonable for the clinician to decline to prescribe until additional professional advice has been sought.

NHS England provides [policy guidance](#) on items which should not routinely be prescribed in primary care.

4.7. Prescription requests from dentists

The [BMA](#) provides advice in relation to prescriptions received from dentists and patients presenting with dental problems.

4.8. Prescriptions issued in another UK nation

Prescriptions issued in one UK nation can be collected in another. [Annex E](#) provides detailed information on fees and links to additional guidance.

4.9. Repeat prescriptions

There are several ways patients can request repeat prescriptions from this organisation:

1. Using their NHS account
2. Using an online service or app
3. By submitting the prescription counterfoil in person or by post

If using the counterfoil, individual items **must** be ticked. It should not be assumed the patient needs all items. When items are not ticked, the patient is to be contacted and clarification sought.

To minimise the risk of error, this organisation **does not** accept telephone requests for repeat prescriptions.

4.10. Repeat prescription intervals

The [BMA](#) advises that prescribers are to provide prescriptions for intervals they feel are clinically appropriate. Six or twelve months' supply on one prescription is acceptable as this is cost-effective and convenient for patients.

4.11. Repeat prescription quantities

While it is considered good practice to prescribe 28 days' supply, it may be more cost-effective and time-efficient to supply 56 days medication, particularly for those patients who are stable and on non-complex regimes.

For some patient cohorts, seven day prescriptions may be appropriate, particularly for clinical and safety reasons, such as those at risk of medication overuse due to confusion or self-harm or those using a monitored dosage system (MDS) device.

The decision for repeat prescription quantities always rests with the prescriber.

4.12. Requests for repeat prescriptions

Repeat prescriptions may be requested by the following:

- Patients
- Nominated representatives (carers, family members etc.)
- District or specialist nurses*
- Pharmacists*
- Care home staff*

* By prior arrangement only

Individuals requesting repeat prescriptions are to be advised that it can take at least 48 hours for a repeat request to be processed (excluding weekends and public holidays).

4.13. Repeat prescription requests for travel

The [BMA](#) explains that the NHS will supply medication for patients who are travelling or moving abroad for a period of up to three months. Patients travelling for more than three months must make their own arrangements to have their medication prescribed in the country they are visiting.

4.14. Medication not appropriate for repeat prescribing

The following medications are not considered appropriate for repeat prescribing:

- Antibiotics, antivirals and antifungals for acute infections
- Cholecalciferol (Vitamin D)
- Hypnotics

- Benzodiazepines
- Nutritional supplements
- Oral or topical corticosteroids
- Antipsychotics (in the elderly)
- Strong opioids

Should a prescriber have any doubt about the appropriateness of repeat prescribing, they are to contact the prescribing lead or pharmacist.

4.15. Repeat prescription process

A table depicting the process for requesting and processing repeat prescriptions can be found at [Annex F](#). Clinicians are to make certain that the repeat record is correct, quantities are synchronised (to minimise wastage) and review dates are entered. A letter to patients regarding synchronisation can be found at [Annex G](#).

5. Controlled drugs

5.1. Classes and schedules

A list of the most commonly encountered drugs currently controlled under [The Misuse of Drugs Regulations 2001](#) can be [accessed here](#). The list details the class and schedule of the drugs. It should be noted that this list is not exhaustive.

5.2. Governance

At this organisation, there is a nominated person with overall responsibility for the management of controlled drugs (CDs). This responsibility is annotated in their terms of reference/job description.

5.3. Requisition of CDs

As detailed in CQC GP Mythbuster 28: Management of controlled drugs, schedule 2 or 3 CDs are to be ordered using the mandatory [FP10CDF CD Requisition Form](#). Additional guidance is available from [NHSBSA](#).

5.4. Storage of CDs

This organisation will adhere to the storage guidance detailed in [CQC GP Mythbuster 28: Management of controlled drugs](#) while also adhering to the [Misuse of Drugs \(Safe Custody\) Regulations 1973](#) and [NICE guideline: NG46](#).



The prescribing lead is responsible for holding the keys to the CD cupboard at this organisation but may delegate this responsibility to the Practice Manager. However, overall accountability rests with the prescribing lead.

5.5. Out-of-date/unwanted/returned CDs

Should any CDs be returned that are out of date, unwanted or returned by patients for disposal, they are to be stored in the CD cupboard until they can be disposed of appropriately. They must be segregated from any in-date stock. [Annex H](#) details the process of dealing with such CDs.

5.6. Clinicians' bags

Clinical staff at this organisation are to adhere to the guidance detailed in [CQC GP Mythbuster 28: Management of controlled drugs](#) regarding clinicians' bags and CDs.

5.7. Record keeping

As detailed in [Schedule 20 of The Misuse of Drugs Regulations 2001](#), a Controlled Drug Register (CDR) must be held at the premises where the CDs are held. The register must not be stored in the CD cupboard, instead it should be stored safely and within proximity to the cupboard.

Register requirements and good practice for maintenance are detailed in [CQC GP Mythbuster 28: Management of controlled drugs](#).

5.8. Disposal of CDs

CDs must be denatured (ampoules opened and tablets crushed) before disposal. A '[Waste Exemption: T28 sort and denature controlled drugs for disposal](#)' registration is to be obtained.

SPS provides [detailed guidance](#) on denaturing CDs and disposing of CD waste. Prior to the disposal of any Schedule 2 CDs, the regional CDAO is to be [contacted](#) as they can provide a list of authorised witnesses to support the disposal process.

Disposal requirements are detailed in the table below.

Disposal requirements for CDs			
	Is denaturing required?	Witness required?	Record of actions



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Unwanted, expired, or obsolete stock (held by the practice)	Yes, for Schedule 2, 3 and 4 (Part I)	Yes, for Schedule 2; good practice for Schedule 3	Schedule 2 – record in the CDR; good practice to record Schedule 3
Patient returned CDs	As above	No, but it is good practice to have the disposal witnessed	Unless the CDs are recorded in the CDR, there is no requirement to annotate the disposal but a separate record should be retained for audit purposes

Once disposal is complete, an entry detailing the destruction is to be made in the CDR and countersigned by the witness. A [CD Destruction Visit Record sheet](#) will be completed by the CDAO or authorised witness (see this example).

5.9. Self-assessment

The regional CDAO is required to request periodic self-assessment declarations from the organisation regarding its management and use of CDs in line with the [Controlled Drugs \(Supervision of Management and Use\) Regulations 2013](#). This assessment will relate to the activities undertaken in the last 12 months and activities to be undertaken in the next 12 months involving CDs Schedule 2 and 3 only. The regional CDAO will provide the self-assessment and declaration form.

The CDAO is permitted to enter organisations and inspect records and stocks of CDs and is also responsible for arranging periodic inspections of organisations.

5.10. Prescribing CDs

As detailed in [CQC GP Mythbuster 28: Management of Controlled Drugs](#), prescriptions for Schedule 2 and 3 CDs can be sent electronically via the EPS and signed with an Advanced Electronic Signature (AES) as well as being handwritten.

Prescribers at this organisation are to limit the quantity of Schedule 2, 3 and 4 CDs prescribed to amounts that meet the patient's clinical need for up to 30 days' supply. Independent prescribers can prescribe any CD listed in Schedules 2 to 5 for any medical condition within their scope of practice/competence.

CPE provides [detailed guidance](#) on CD prescription form validity that conforms to [The Human Medicines Regulations 2012](#) and [The Misuse of Drugs Regulations 2001](#).

5.11. Prescription validity

Prescriptions for Schedule 2, 3 and 4 drugs are only valid for 28 days after the appropriate date (i.e., date of signing unless the prescriber states a date before which the CD should not be dispensed).



5.12. Private prescriptions

When Schedule 2 and 3 drugs are prescribed privately, they are to be written on FP10PCD forms or prescribed via the EPS. There may be occasions whereby prescribers may need to apply for a private prescriber ID number via NHSBSA before they are able to prescribe CDs privately.

5.13. Collection of CDs

When CDs are collected by the patient or their representative, they are to sign for the CDs in the designated box on the reverse of the FP10PCD. **Note**, for Schedule 2 CDs it is a legal requirement to obtain proof of ID from the individual collecting the medication. Confirmation of the ID is to be annotated in the medical record.

It is also a legal requirement for dispensary staff to determine if the person collecting the CDs is the patient, a representative of the patient or a healthcare professional acting on behalf of the patient.

5.14. Standard Operating Procedures (SOPs)

In accordance with the Regulations of Controlled Drugs 2013, it is a requirement for this organisation to have a range of SOPs relating to CDs. This organisation will liaise with the lead pharmacist at the local Integrated Care Board (ICB) to determine the content of the SOPs. The CQC recommends the following SOPs:

- Obtaining and receiving
- Storing
- Prescribing
- Dispensing and supplying
- Destruction
- Transporting
- Stationery

5.15. Monitoring safe prescribing

The prescribing lead will regularly review the prescribing of CDs at this organisation using the [NHSBSA safer prescribing dashboard](#).

6. Cytotoxic drugs

6.1. Risk



Any member of staff is at risk of exposure if they are working with a patient who is receiving cytotoxic drugs. Risk is particularly relevant for staff who are involved in the preparation and disposal of cytotoxic drugs. Exposure may be through skin contact, absorption, inhalation, ingestion and potentially needle-stick injuries.

6.2. NICE guidance

NICE provides the [following guidelines](#) which are to be adhered to by all staff at risk of exposure at this organisation:

- Cytotoxic drug handling guidelines
- Safe systems for cytotoxic medicines
- Cytotoxic drugs: important safety information

6.3. Risk reduction

Cytotoxic drugs must be managed in accordance with the [Control of Substances Hazardous to Health \(COSHH\) Regulations 2002](#). Therefore, a COSHH risk assessment must be completed for all cytotoxic drugs held by this organisation.

6.4. Personal Protective Equipment (PPE)

PPE must be worn by all personnel when dealing with cytotoxic drugs; this should include:

- Gloves
- Apron
- Eye protection (the most suitable being safety glasses where the entire periphery of the goggle is in contact with the face)
- Mask*

* FFP3 masks should be worn by staff when dealing with spillages of cytotoxic drugs.

6.5. Dealing with spillages

Cytotoxic spillages should be managed using cytotoxic spill kits. Immediate actions are:

- Isolate the area
- Alert staff and inform the Practice Manager
- Turn off all fans
- If the person spilling is exposed/contaminated, a separate individual should deal with the spillage

- Use the cytotoxic spill kit and follow the guidance enclosed
- An incident form should be completed if an individual is contaminated

If any doubt exists, guidance should be sought from the local area team and the drug manufacturer.

6.6. Disposal

Cytotoxic waste must be disposed of appropriately in containers clearly identified for cytotoxic waste; this includes bags, bins and sharps bins. The colour for such receptacles is purple as illustrated below.



6.7. Monitoring controls

At this organisation, monitoring takes place periodically to ensure that staff are competent with the requirements for the management of cytotoxic drugs. Furthermore, staff who are pregnant or planning to conceive should seek advice from the local Occupational Health Team as there are significant risks associated with cytotoxic drugs and pregnancy.

7. Medication reviews and monitoring

7.1. Routine medication reviews

At this organisation, medication reviews will be carried out at least annually or, in cases of complex repeat prescriptions, every six months. Reviews will be conducted with the patient and will either be face to face, telephone or video consultations.

The individual undertaking the review is to ensure that:

- The prescribed medication is appropriate for the patient's needs
- The medication continues to be effective
- All monitoring and chronic disease reviews have been completed
- The medication is the most cost-effective choice



- There are no drug interactions or side effects
- The patient remains compliant
- The review is recorded in the patient's healthcare record appropriately
- The appropriate SNOMED CT code is used
- The review date is amended

7.2. Failure to attend a review

Every attempt must be made to contact the patient to determine the reason why they have not attended their review and to rearrange the review. All attempted interactions are to be recorded on the clinical system.

7.3. Patients discharged from hospital

[NICE guideline \[NG5\]](#) outlines the need for the sharing of relevant information about an individual's medication, particularly changes to medication, including medicines started or stopped, dosage changes and the reason for such changes.

At this organisation, all discharge letters/summaries will be reviewed and, when necessary, an appointment made to review the patient. It is imperative that the patient has sufficient medication and, if necessary, the clinician reviewing the discharge information is to issue an acute prescription.

7.4. Awareness of misuse

As outlined by the [GMC](#), during the review prescribers are to be aware of the signs of poor adherence, such as the patient requesting repeat prescriptions earlier or later than expected. Prescribers must ensure that the patient is taking their medication(s) as directed, that they are effective and the patient is tolerating them. Early intervention is key in any potential misuse cases.

Should it be considered that a patient is continually misusing their medication, they will receive a letter ([Annex I](#)) providing further guidance and reassurance. Should it be deemed necessary, the patient will also be issued with a repeat ordering proforma ([Annex J](#)).

7.5. High risk drug monitoring

The CQC will use [Ardens searches](#) on the clinical system to determine the effectiveness of high-risk drug monitoring. [CQC GP Mythbuster 12: Accessing medical records and carrying out clinical searches](#) provides further detailed information.

This organisation will adhere to the recommended regular monitoring periods for high-risk drugs as outlined by [SPS](#). This guidance also includes the required baseline tests.

7.6. Medicines optimisation



[NICE](#) defines medicines optimisation as a person-centred approach to safe and effective medicines use to ensure people obtain the best possible outcomes from their medicines. This organisation will adhere to [NICE NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes](#) and [NHS England's medicines optimisation guidance](#) to ensure patient outcomes are improved.

7.7. Medicines Optimisation Peer Review

Medicines Optimisation Peer Review is a mechanism used to encourage prescribers in their decision-making processes to deliver safe, evidence-based, cost-effective prescribing. Data can be retrieved from the [Medicines Optimisation dashboard](#), enabling users to develop plans to enhance patient outcome and service delivery.

8. Medication shortages

8.1. Stock shortages

The NHS England [A guide to managing medicines supply and shortages](#) should be consulted should there be any medicine supply shortages. This guidance document includes actions that will be taken from various organisations following the notification of a medicine shortage.

Stock shortage notifications may also be received from the Medicines & Healthcare products Regulatory Agency (MHRA) [Central Alerting System](#).

8.2. Patient safety concerns with stock shortages

If stock levels or supply issues become a patient safety concern then the process as detailed within the Significant Event and Incident Policy is to be followed.

Should there be any notification from the [National Patient Safety Alert](#) (NPSA), then this will be managed as requested by the National Patient Safety Alerting Committee NaPSAC and in liaison with the ICB Medicines Optimisation Team.

9. Adverse reactions

9.1. Reporting process

If a patient has an adverse reaction to a drug, it should be reported using the [MHRA 'yellow card' scheme](#) and a Significant Event raised.

10. Emergency medicines

10.1. Guidance

Detailed guidance regarding the availability of emergency medicines in the organisation and for healthcare professionals conducting home visits can be found in [GP Mythbuster 9: Emergency medicines for GP practices](#).

The CQC would expect to see evidence that an appropriate [risk assessment](#) has been conducted. This is to identify a list of medicines that are not suitable for an organisation to stock and how this is kept under review.

For additional information, see the Medical Emergencies Guidance Document.

11. Audit

11.1. Prescribing audit

Conducting a prescribing audit will enable the organisation to review current prescribing performance and patterns. For further detailed information, see the Quality Assurance and Clinical Audit Policy

12. Cold chain management

12.1. Overview

The cold chain is a term used to describe the cold temperature conditions in which certain products need to be kept during storage and distribution. Maintaining the cold chain ensures that products are transported and stored according to the manufacturer's recommended temperature of +2° to + 8°C and protected from light and transferred to a fridge promptly after delivery until the point of administration. The cold chain process is multifaceted and is detailed within [The Green Book Chapter 3](#).

12.2. Receipt of cold chain products

The process of receiving cold chain products is detailed at [Annex K](#).

12.3. Storage of cold chain products

All cold chain products must be stored as detailed in the [Green Book Chapter 3](#). To optimise efficiency, the following best practice principles should be adhered to:

- Maintain an average fridge temperature of 5°C

- Separate vaccine types within the fridge for ease of identification
- Use labels on the exterior of the fridge to show the location of the vaccine type and expiry date
- Stock rotation must be effective; items with the shortest expiry date should be placed at the front to be used first

12.4. Refrigerator specifics

The vaccine fridge should have the sole purpose of storing vaccines. It should not be used for the storage of any other products. In particular, the fridge should:

- Be clearly identified as a vaccine fridge
- Undergo regular portable appliance testing as detailed within the Health, Safety and Risk Management Handbook
- Have a functioning locking mechanism or be stored in a locked room
- Be clean, sited appropriately and not overfilled
- Have an external maximum – minimum thermometer in place as well as the integrated thermometer
- Undergo a regular servicing programme which is auditable
- Be defrosted (if an icebox is fitted) regularly and this information recorded for audit purposes
- Have an uninterrupted electricity supply (switchless socket) or, where necessary, have the socket clearly labelled 'vaccine fridge do not turn off'

12.5. Temperature monitoring

Fridge temperatures should be recorded at least once daily. The recording process is formed of four stages (the four Rs):

1. **Read:** daily reading of the thermometer's maximum, minimum and current temperatures at the same time daily during the working week
2. **Record:** recording temperatures in a standard fashion, on a standard form, including signing each entry on the recording sheet (note, this can be done digitally)
3. **Reset:** resetting the thermometer after each reading. The thermometers should also be reset when temperatures have stabilised after periods of high activity

4. **React:** the person making the recording should act if the temperature falls outside +2° to +8°C and document this action

Ideally, use a second thermometer independent of the integral thermometer in the vaccine fridge. This second reading cross-checks the accuracy of the temperature. It monitors the temperature if the electricity supply to the fridge is interrupted.

12.6. Cold chain breach

The UKSA [Vaccine incident guidance – Responding to errors in vaccine storage, handling and administration](#) provides comprehensive guidance on the prompt actions that should be taken in the event of a cold chain breach or compromised storage event.

12.7. Promoting best practice

A poster to promote best practice is available to order using this [link](#).

12.8. Audit

A template for a cold chain audit can be found at [Annex M](#).

13. Storage of medicines

13.1. Temperature requirement

Medicines within this organisation are stored in an area that does not exceed 25°C; this is achieved using an air conditioning unit. Due to the levels of medication that are held, plus the cost should these be rendered unusable, the air conditioning unit is set at a suitable temperature to ensure that the medicines are not spoiled. It is not set for the comfort of the staff.

Additional information can be found in [Professional guidance on the safe and secure handling of medicines](#).

13.2. Temperature monitoring

The temperature within the storage area is to be monitored as follows:

- a. Daily, the thermometer is to be checked with readings taken for the minimum, maximum and current temperatures since these were last recorded. The thermometer is to then be reset
- b. Should the temperature need to be changed then the air-conditioning unit regulator should be changed to reach the desired temperature
- c. As required, the temperature should be rechecked in an hour to ensure that the required heat has been met



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- d. All actions are to be recorded upon the medicines store temperature check form at [Annex N](#). Any remedial action is also to be logged
- e. All check forms are to be kept for a period of 12 months for future reference and evidence of compliance
- f. Should the ambient temperature be nearing 25°C, action must be taken to cool the area such as using fans, increasing the output of the air conditioning or opening/closing windows and doors. In these circumstances, the temperature should be monitored closely until the temperature has reduced
- g. Should temperatures exceed or be found to read higher than 25°C, then the nominated individual should be informed immediately so that further action can be taken if needed. All actions are to be recorded on the data sheet

14. Storage of medical gasses

14.1. Overview

Detailed guidance on the storage of medical gasses can be found in the Health, Safety and Risk Management Handbook at Annex N. This guidance also includes an audit template and risk assessment for medical gasses.

15. Central Alerting System (CAS)

15.1. Overview

It is the responsibility of all staff at this organisation to take the necessary actions regarding CAS alerts. The CAS Lead is responsible for the timely dissemination of all alerts and ensuring that subsequent actions are taken to demonstrate compliance with the alert(s).

15.2. Types of alerts

The following alerts are available on the [CAS](#):

- NHS Improvement Patient Safety Alerts (PSA) and Estates Alerts
- Medicines and Healthcare products Regulatory Agency (MHRA) Dear Doctor letters
- Medical Device Alerts (MDA) and Drug Alerts
- Chief Medical Officer (CMO) Alerts
- Department of Health and Social Care Supply Disruption alerts

The [CAS](#) is a web-based cascading system for issuing patient safety alerts, important public health messages and other critical safety information and guidance to the NHS and others including independent providers of health and social care.

15.3. Responding to alerts



In the interests of patient safety, it is vital that this organisation has efficient and effective systems in place to process, disseminate and act on the information received in CAS alerts. A safety alert can be defined as a notification to prevent or avoid unexpected or avoidable harm or injury to a patient, carer, staff or visitor or to prevent fraud. The flow chart at Annex O details the process for actioning all alerts at this organisation.

15.4. CQC expectations

CQC expectations in relation to patient safety alerts are detailed in [GP Mythbuster 91: Patient safety alerts](#). It is considered good practice to retain a log of alerts which details the action(s) taken upon receipt of an alert. All alerts can be recorded using [Safety Alerts Manager](#) in the Practice Index HUB.

15.5. Searching for alerts

Alerts can be searched for by using the 'search all alerts and broadcasts' feature of the [CAS](#) or the search filter in the Practice Index HUB.

15.6. The Yellow Card Scheme

Staff at this organisation have a duty to report any adverse reactions to medicines, or an adverse incident relating to a medical device, using the [Yellow Card Scheme](#). The scheme allows the MHRA to monitor the safety of all healthcare products in the UK to ensure they are acceptably safe for patients and those who use them. The Yellow Card alerting system is also available via the [Yellow Card App](#).

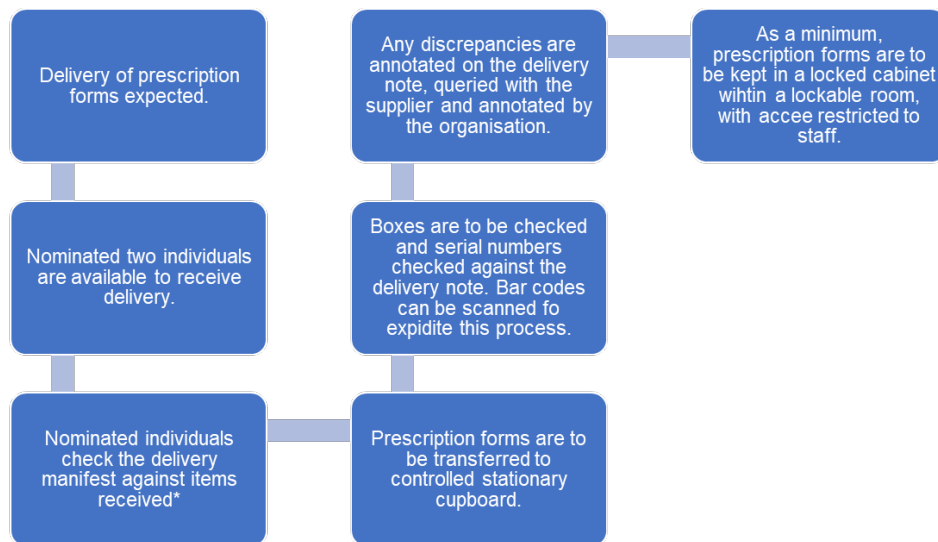
15.7. Reporting estates defects and failures

NHS healthcare providers should report defects and failures involving engineering plant, infrastructure and non-medical devices to the Department of Health. Defects and failures are to be reported online using the [efm-information system](#). Any defects or failures reported must be recorded in the organisation's defect log.

Annex A – Paper prescription log template

Date order	Order by	Quant order	Date receiv	Quant receiv	Receiv by	Serial numbe receive	Store by	Serial numbe issue	Issue to	Signat

Annex B – Delivery and storage process



*This action is to be carried out before the delivery driver leaves the organisation.

Annex C – Incident response table

Nature of incident	Who should be contacted?
If prescription forms are lost through negligence or by accident.	Notify the designated person with overall responsibility for prescription forms at the organisation, the CDAO and police as required. Report the matter using the organisation's incident reporting system. An alert/warning may be circulated locally and/or regionally. If fraud is suspected, details of the incident must be reported to the NHS CFA.
If prescription forms are stolen.	Contact the police and report the matter using the organisation's incident reporting system. Notify the CDAO and those responsible for security. An alert/warning may be circulated locally and/or regionally. If fraud is suspected, details of the incident must be reported to the NHS CFA.
If it is suspected that a presented prescription form is forged or counterfeit.	Check with the prescriber then, if appropriate, notify the CDAO, police and report to the NHS CFA via the NHS Fraud & Corruption Reporting Line 0800 02840 60 or online.
If it is suspected that prescription forms are being misused.	Check with the prescriber then, if appropriate, notify the CDAO, police and report to the NHS CFA via the NHS Fraud & Corruption Reporting Line 0800 02840 60 or online.

Annex D – Risk assessment template

Risk assessment title		Date of assessment	
Assessment conducted by		Date of next review	
Contributors		Risk reference	

What are the potential hazards?	Who is at risk of being harmed and how?	What are you already doing to control the risks?	Risk rating	Additional control measures	To be implemented by who, by when?	Residual risk
Patient state they have their prescription	Patients or members of the public state they use medication which has not prescribed for but acquired using lost prescription	The organisation maintains a record of any claims of lost prescriptions by patients. Discuss circumstances of the loss with patient. Check with local pharmacies to see if prescription has been dispensed. If the lost prescription form is for a CD, the CDAO is to be informed to enable additional control measures to be implemented	6	To carry out spot checks to ensure staff understand the actions taken in the event of a patient presenting with a prescription. Provide refresher training to staff on an as required basis.	Prescribing lead to carry out ongoing Prescribing lead to carry out ongoing Pharmacists - to carry out ongoing	6

		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Consequence	5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
	4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
	3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
	2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
	1 Negligible	1 Low	2 Low	3 Low	4 Moderate	6 Moderate

Annex E – Prescriptions issued in another nation

Detailed information regarding prescriptions issued in another UK nation.

a. England

The table below shows when charges will be incurred should a Scottish, Welsh or Northern Irish prescription be presented in England.

Origin of prescription	Charges
Scotland	Collect prescription charges according to English rules unless the patient qualifies for exemption
Wales	Collect prescription charges according to English rules unless the patient presents a Welsh prescription charge entitlement card
Northern Ireland	No prescription charge

b. Scotland

Patients who live in England but are registered with a GP practice in Scotland will not be charged for a prescription(s) presented for dispensing in Scotland. They will not require any entitlement card as they will have been issued with the Scottish prescription form (GP10).

If a patient presents a Scottish prescription for dispensing at a pharmacy in England, they will be required to pay the English charge unless they fall within one of the exemption categories listed in the equivalent English regulations.

Any Scottish prescription form presented for dispensing in Wales or Northern Ireland will be charged the rate in force at the time. Currently this is no charge.

Patients presenting prescriptions written in England will be charged at the English rate per item. The only exceptions are for entitlement card holders or those who qualify for exemption.

Patients presenting a prescription(s) written in Wales or Northern Ireland for dispensing in Scotland will not be charged under current arrangements.

c. Wales

NHS prescriptions are free of charge if the patient has:

- A GP who works for NHS Wales, and;
- The prescription is dispensed by a pharmacy that is employed by NHS Wales

If the patient lives in England and has a GP in Wales, they can get prescriptions free of charge if the prescription is dispensed by a pharmacy employed by NHS Wales. If the patient chooses to have their prescription dispensed in England, they will have to qualify for free prescriptions under the English criteria.

If the patient lives in Wales and has a GP in England, they may still be able to get prescriptions free of charge by having an exemption card. Further information is available on the [NHS Wales Help with Health Costs website](#).

Patients can apply for exemption cards to the following address:

NHS Prescription Card Exemption
NHS Wales Shared Services Partnership
Cwmbran House
Mamhilad Park Estate
Mamhilad
PONTYPOOL
NP4 0YP

If the patient has an NHS prescription dispensed in England, they will be charged at the rate set by the DHSC in England.

If the patient has been referred by their local Health Board to a hospital in England and is given an English prescription, they will have to pay the current rate set by the DHSC even if they take it to a Welsh pharmacy. However, provided the patient is a Welsh resident, they may claim this fee back from the NHS Wales Shared Services Partnership if they have proof of payment.

Further reading can be found in the NHS E document titled [England/Wales Cross Border FAQs](#).

d. Northern Ireland

Prescriptions written at a GP practice are dispensed free of charge in Northern Ireland, therefore pharmacists in Northern Ireland will not charge patients from England, Scotland or Wales as detailed [here](#).

If the patient takes a Northern Ireland issued prescription to a pharmacy in England, Scotland or Wales, the pharmacist will not charge for dispensing this.

Further information on UK prescription charges can be found at the NHSBSA document [here](#).

Annex F – Repeat Prescription Process

Step 1	Request received • Check patients' details (name, address, and date of birth) • Check request is an authorised repeat medication, the drug name, strength, dose and form are identical to the repeat list • Check the repeat medication review date has not been exceeded If there are no issues, go to Step 3.
Step 2	Refer to prescriber if any of the following issues are identified: • The number of repeat issues has been met • Requests received earlier or later than expected (may indicate poor compliance by the patient) • A repeat has not been requested for a period of 12 months (except for seasonal medications) • No repeat date has been set
Step 3	Prescription request accepted • Generate prescription and pass to prescriber for signature who will: ○ Ensure correct patient is issued with the correct prescription ○ The correct dose is prescribed ○ Appropriate directions for use are shown ○ Review patients record, medicine usage and effects • Prescriber returns the prescription to the designated area and it is retained until collected.
Step 4	Prescription collection • Staff cross-reference information on the prescription with the person collecting • Prescription passed to patient or their representative

Notes.

1. Prescriptions not collected after 28 days are to be discussed with the prescribing clinician who will update the patient's medical record using the appropriate SNMOED CT code. The prescription form is then to be shredded.

2. Patients under 16 years of age are not permitted to collect prescriptions unless prior arrangements have been made between this organisation and the parents or guardian of the patient.

Annex G – Synchronisation letter template

Dear [insert name of patient],

The aim of medication synchronisation is to order all your repeat medication at the same time each month rather than multiple requests throughout the month. Synchronising saves time for you, your GP and pharmacy staff.

To initiate the synchronisation of your medication, when you next need to request an item on repeat, count all the tablets you have and annotate the table accordingly. Your GP will issue a “one-off” prescription of the tablets you need to synchronise all your medication to within a day or two.

Please complete the table below and submit it with your next repeat prescription.

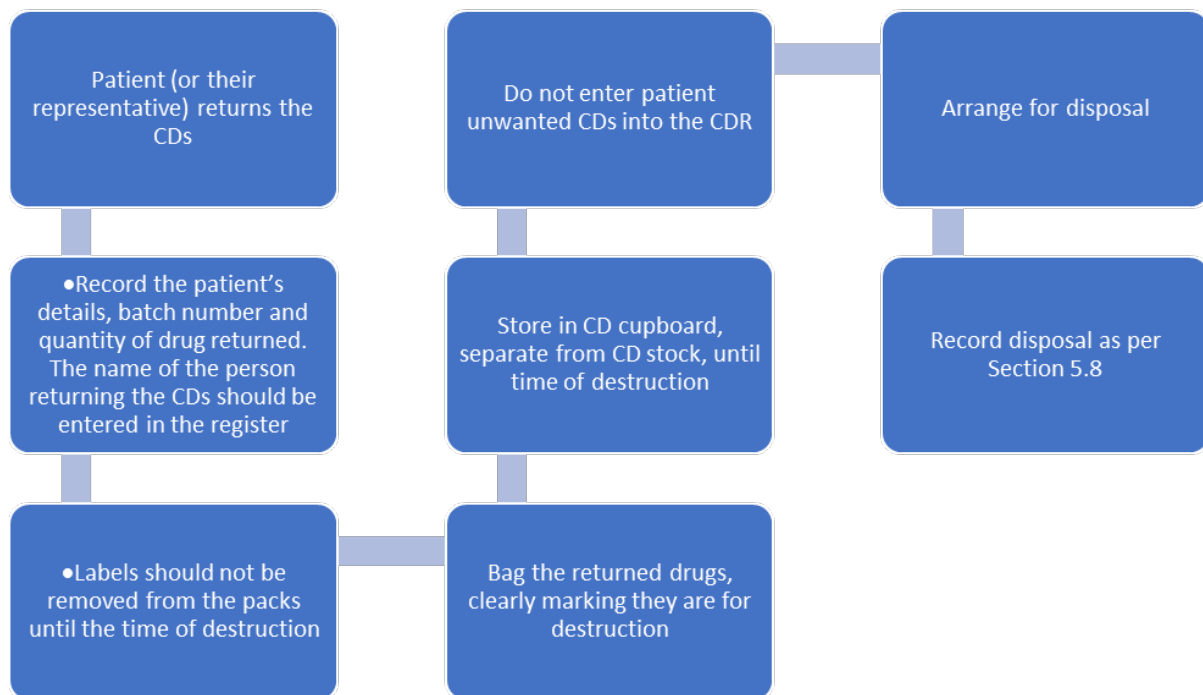
✂-----

Patient name		Clinical number	
Date of birth		Contact number	

Name of medication	Strength	Dose	Quantity remaining
<i>Aspirin</i>	<i>75mg</i>	<i>Once a day</i>	<i>8</i>

Annex H – Receiving unwanted or returned CDs

The following process is to be adhered to when receiving unwanted, out of date or returned CDs.



Annex I – Monitoring letter template

Dear [insert patient name],

You recently attended Elixir Medics for an appointment with [insert clinician]. The purpose of this appointment was to undertake a medication review.

During the consultation, the clinician reviewed your current repeat medication and your compliance with the medication while also reviewing your current clinical condition(s). As a result of [insert reasons here], [insert clinician] has, with your best interests at the forefront of their mind, requested that all your repeat prescription requests are monitored for a period of [insert number] months.

The following actions were agreed during your consultation:

- Repeat prescriptions will be ordered in accordance with the medication record
- Repeats may only be ordered as per the order date stated on the record
- You attend the practice and hand in your repeat requests accompanied by the medication record
- Your medication record will be returned to you when you collect your repeat prescription
- Any requests falling outside the order record are to be discussed with [insert clinician]
- Attendance at regular medication review meetings is necessary. The next meeting is scheduled for [insert next medication review date]

To ensure continuity of care, please continue to book appointments with [insert name of clinician]. Should you wish to discuss any element of this letter or your current medication, please contact the practice and book an appointment with your clinician.

It is essential that you comply with the conditions detailed above which focus on providing you with an optimal level of care. Please sign and return the enclosed copy of this letter as soon as possible.

Yours sincerely,

[Insert name of clinician]

I, ..., agree to comply with the conditions detailed above.

Signed:.....

Dated:.....

Annex J – Repeat medication ordering pro forma

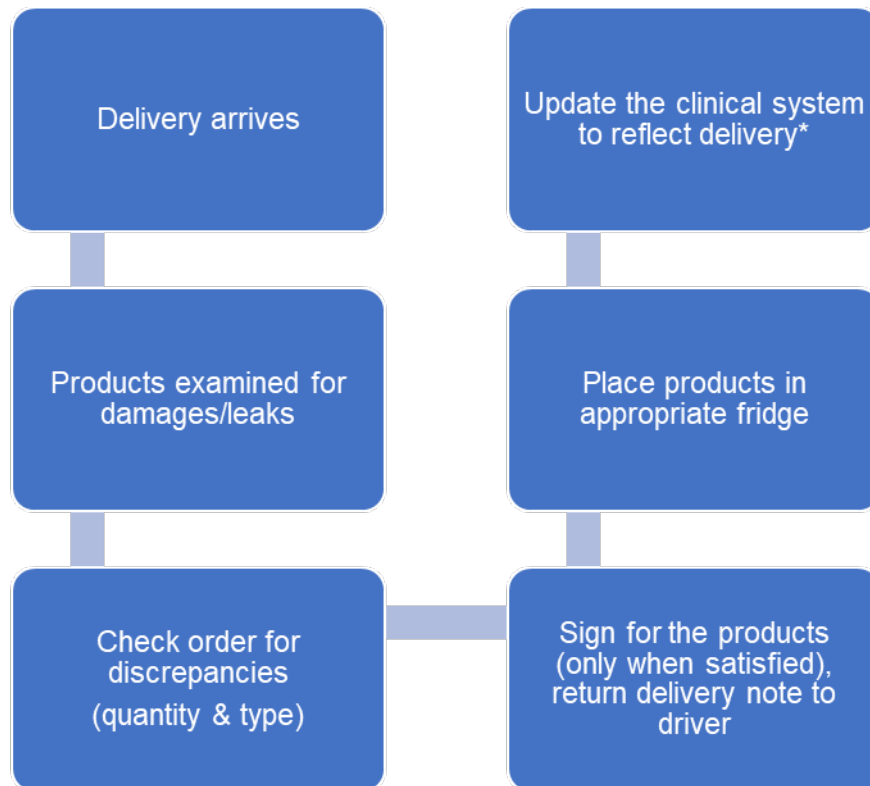
Patient name	
Date of birth	
Address	
GP	

This pro forma is to be submitted alongside every repeat prescription and will be returned upon collection of your prescription. The order date shown below is the earliest date that you may submit your request. Should you need to discuss this, please book an appointment with the GP named above.

Medicati	Strength and form	Direct	Quant	Next or date	Issued	Date authori

Annex K – Receiving cold chain products

The diagram below illustrates the process for receiving cold chain products.



* Update to include the following:

- Vaccine/product type and brand
- Quantity received
- Batch number and expiry date
- Date and time of receipt

Annex L – Fridge temperature monitoring record

[Insert organisation name]

[Insert fridge reference and location]

Date	Time	Current Temp	Min Temp	Max Temp	Signature & initials	✓ to confirm reset	Comments
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
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16							
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27							
28							
29							
30							

31							
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TEMPERATURE RECORD FOR THE MONTH OF [month] [year]

Annex M – Cold chain audit template

Criteria	Audit re			Required act	Targ date	Date compl
	Yes	No	N/A			
Policy and procedure						
Does the practice have an up-to-date cold chain policy (within the last two years) that is accessible to all staff?						
Have all staff handling vaccines, from receipt to storage, been trained to follow policies to ensure correct handling?						
Are there at least two trained people responsible for receipt, and care of vaccines?						
Storage and stock control						
Are vaccine stocks monitored prior to order?						
Is there more than four weeks' supply of vaccine on hand?						
Are the expiry dates of vaccines monitored and stock clearly labelled?						
Is stock rotation carried out to ensure shortest dated stock used first?						
Is not more than 66% of the internal volume of the refrigerator used?						
Are items stored away from the back and the freezer compartment if it has one?						
Receipt of vaccines						
Are vaccines checked against the order for correct type, quantity, leakage or damage before signing for them?						
Is there a procedure for recording the date of receipt, vaccine types, brands, quantities, batch numbers and where received?						
Are vaccines refrigerated immediately on receipt?						
Refrigerator						
Is the refrigerator of adequate size to store the number of vaccines required?						
Is the refrigerator dedicated to pharmaceuticals only?						
Is anything other than vaccines stored in the refrigerator?						
Is the refrigerator either both lockable and in a secure room?						

Is the electricity supply safe, e.g., switchle notices in place to prevent accidental unpl						
Are there contingency arrangements in pla frigerator failure or power cut including ba						
Are there records of regular servicing, def per the manufacturer's recommendations?						
Temperature monitoring						
Is there a named person and deputy respo the fridge?						
Are procedures in place for <i>at least</i> daily r ures?						
Is an appropriate recording form used?						
Are the minimum, maximum and actual te erator monitored and recorded and acted						
Is the four R's process followed?						
Are thermometers calibrated and serviced						

Date of audit:

Name of person completing audit:

Role of person completing audit:

If there are required actions, is there a plan in place to complete: Yes or No*

Date actions completed:

Signature:

Print name:

* Delete as applicable

Annex N – Storage temperature monitoring record

[Month and year]

Date	Time	Current Temp	Min Temp	Max Temp	Signature	✓ to confirm reset	Comments
1							
2							
3							
4							
5							
6							
7							
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10							
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Annex O – Alert processing flow chart

