ROYAL PHARMACEUTICAL SOCIETY

Professional Standards for optimising medicines for people in secure environments

Immigration Removal Centres (Edition 1)

England

February 2017

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1. INTRODUCTION

In 2003 the Department of Health published "A Pharmacy Service for Prisoners"[1]. This made 30 recommendations which set out a way forward in the development of more patient focused, primary care based pharmacy services to prisoners based on identified need. Implementation of these recommendations, coupled with the transfer of commissioning of health and pharmacy services to the NHS in 2005, has resulted in improved pharmacy services for people in prison with improved medicines governance and a larger pharmacy workforce that deliver these services and support the wider healthcare and custodial teams.

In 2013, NHS England was given responsibility for directly commissioning healthcare services to:

- HM Prisons and Young Offender Institutions
- Secure Training Centres and Secure Children's Homes
- Immigration Removal Centres (from September 2014).

To facilitate a single national service specification for these settings, pharmacy services were included as a separate section of the specification alongside a medicines standards supplement. These fully adopted the principles of medicines optimisation[2] and have been used in the procurement process and underpin service monitoring and development within the commissioning cycle.

In 2014, the RPS published Professional Standards for Hospital Pharmacy Services (England, Scotland and Wales), the scope of these standards included providers of pharmacy services in prisons. The NHS England Immigration Removal Centres Medicine Improvement Programme Working Group, working with the health and justice sector, have reviewed the RPS Hospital Standards, alongside recommendations in the Shaw Review[3], and developed new professional standards for optimising medicines for people in secure environments. The new standards, hosted and published by the RPS, are for use in England but may also be a useful reference in Wales and Scotland. The standards will be published in two editions, with the same domains in both editions and with standards that reflect and describe the context for implementing them in:

- Immigration Removal Centres (Edition 1)
- Prisons, Young Offender Institutions and Secure Training Centres (Edition 2).

IMMIGRATION REMOVAL CENTRES

Immigration Removal Centres (IRC) are a part of Home Office Immigration Enforcement and play an important role in immigration control in the UK.

Detention and removal are essential elements of effective immigration controls and the statutory purpose of the detention facilities is to provide for the secure but humane accommodation of detained persons. **Immigration Enforcement** seeks to ensure the safe, secure and efficient running of the detention estate and escorting services, including removal.

Currently there are nine IRCs in the UK, two of which are managed on behalf of the Home Office by the National Offender Management Service (NOMs), with the other seven being managed by independent contractors. Of these one site (Yarl's Wood IRC) is primarily for female immigration. As part of its responsibilities, Immigration Enforcement, provides secure detention facilities for:

- People who have just arrived in the UK and who are subject to examination by an immigration officer to decide whether or not they can be granted entry to the UK. This can include multiples alias
- People who have entered the UK illegally (for example, in the back of a lorry or using false documents), who are waiting for a decision as to whether they will be granted leave to enter and who are waiting for removal if leave to enter is refused. This category may include people who have applied for asylum

1 DH 2003 "A Pharmacy Service for Prisoners".
2 RPS May 2013 Medicines optimisation: helping patients to make the most of their medicines. Good practice guidance for healthcare professionals in England).
3 Stephen Shaw Jan 2016 Review into the Welfare in Detention of Vulnerable Persons – A report to the Home Office.

- People who have overstayed their limited leave to remain, or who have breached conditions attached to their leave to remain, and who are waiting for a decision about whether they are to be removed from the UK, or pending their removal
- People against whom the Home Office is taking deportation action. Most people in this position will be foreign national offenders who have completed their criminal sentence.

Most people detained under immigration powers spend only very short periods in detention. Of the people leaving detention during the year ending June 2016, 64% had been in detention for less than 29 days and 94% for less than four months. For the calendar year 2015, 62% left detention within 29 days and 92% in less than four months. A percentage of detainees will also come directly from prison detention and exhibit challenging or violent behaviour. The most challenging of such cases will however remain in the prison estate.

Since 2013, healthcare in the centres in England has been commissioned by NHS England, who are responsible for providing high quality and timely healthcare to detainees. NHS England is responsible for commissioning all services, including consumables, to the detained estate with the exception of urgent care services.

Primary healthcare facilities are provided at residential Short Term Holding Facilities (STHF), the Pre-Departure Accommodation (PDA) and IRCs. All detainees are seen for a healthcare screening by a nurse within two hours of arrival at a residential STHF, IRC or the PDA to identify any issues of concern. In IRCs and the PDA, all detainees are then offered an appointment with a GP within 24 hours. Detainees can then access health care facilities on demand, subject to a triage service similar to those found in GP surgeries in the community.

In addition there exists an Enhanced Care Unit at Harmondsworth IRC which, while not able to provide full in- patient facilities allows care and observation in an environment with 24 hour health input via Health Care Assistants.

In this environment care can be provided for all primary healthcare needs, many physical disabilities. Mental health care is also a strong focus, as a number of detainees may suffer from depression or mental health needs. People may arrive in an IRC having remained in the UK for periods of time without legal basis and therefore without access to healthcare so they may exhibit conditions aggravated by lack of medical attention. Additionally cases of alcohol and drug dependency are common among people who have lived in either poor conditions or rough sleeping. Language communication and healthcare record absence can additionally challenge prompt and comprehensive attention as can a reluctance to engage or comply with healthcare driven by unwillingness to engage generally or an attitude of protest to their detention in general.

The detention environment is regulated by Detention Centre Rules, a set of **Detention Service Orders** (DSOs) provide operational guidance on issues and procedures within them. Some of these are directly relevant to health care issues, including:

- Hospitalised detainees (in preparation)
- Food and Fluid refusal
- Adults at risk
- Medical information sharing
- Women in detention
- Care and management of pregnant women
- Death in detention.

In addition to the above, there are a number of challenges when providing healthcare and medicines to detainees within the IRC environment. These may include:

- Unwillingness by the detainee to share GP/healthcare information due to concern that this information may betray their true identity or history of their time in the UK
- A lack of verifiable information to support *medicines reconciliation* on admission
- The risk of purposeful self-harm or cessation of medicine compliance by a detainee in an effort to frustrate removal by making themselves unfit for air travel
- Food and/or fluid refusal cases

- The risk of a detainee accessing prohibited substances (such as new psychoactive substances, *Controlled Drugs* or homemade alcohol) whilst in the detained environment and the effect this can have on vulnerable detainees
- The natural limitations to complex mental health bed availability and attaining places for specialist services in this area when these facilities are limited within local authorities and there is a knowledge that the person is in an environment with some care already in place, albeit in some cases continued detention could be unlawful (if release documents had been served on the detainee)
- Difficulty to identify non UK medicines or patient having poor knowledge about their current treatment
- The provision of medicine continuity when patient is being removed or released into the community (for example to no fixed abode). On occasion there might not be enough time to arrange medicine to take away. Also patient might be discharged on a treatment regimen that might not be available in the country of destination (i.e. clozapine)
- Challenges to remove patients to countries where tight Controlled Drug Regulation applies. Requirement to provide extra documentation or a reduced amount supplied
- Lack of social care provision in IRCs, for example assisting a disabled detainee to shower.

2. SCOPE OF THE PROFESSIONAL STANDARDS

The standards support the commissioning and development of safe, quality services that put patients and their needs first.

It encourages a multidisciplinary approach between the pharmacy, healthcare and custodial workforce that ensures medicines optimisation is "everybody's business". In health and justice settings, medicines optimisation is often led by the pharmacy team, but medicines are prescribed and handled by a variety of professional and support staff.

These standards are for use by anyone who has a role in optimising and handling medicines.

The 5 domains and 23 standards are structured so they describe the patient journey from admission into the secure setting, optimising medicines during their stay and preparing for release into the community (in the UK or abroad) or transfer into another secure environment. Workforce and governance underpin the patient experience and safety and have specific domains to describe expectations:

- **Domain 1: Arriving and meeting initial medicine needs**
- **Domain 2: Meeting people's medicine needs during their stay**
- **Domain 3: Continuing people's medicines on release and transfer**
- **Domain 4: Employing and training a competent workforce to underpin optimising people's medicines**
- **Domain 5: Maintaining a framework of safety and governance.**

It is acknowledged that individual standards may be relevant in more than one domain – where they are shown relates to the most logical point in the patient journey and underpinning governance framework.

Please note: For the purposes of these standards, in all secure environments commissioned by NHS England, day to day prescribing is written on a customised prescription form which meets the legal requirements for a prescription. These prescriptions are considered NHS prescriptions, including Controlled Drug prescriptions. *FP10 prescriptions* (English NHS prescriptions) are available for use for people in these settings but only for urgent medicines and unplanned releases. Further information about this, FP10 prescriptions and charges can be found on the **NHSBSA website**.

Key terms

A glossary of key terms is provided (Appendix 2) and the words within the glossary are shown as italics and in blue within the standards.

DOMAIN 1: ARRIVING AND MEETING PEOPLE'S INITIAL MEDICINES NEEDS

This domain includes initial arrival from the community and transfer from another secure environment and covers the first few days of care (e.g. up to 7 days).

STANDARD 1: PEOPLE'S MEDICINE NEEDS ARE IDENTIFIED VIA INITIAL RECEPTION SCREENING

1.1 People's initial medication history, including allergies, is captured and recorded, a full *medicines reconciliation* is commenced and completed within 72 hours of admission.

1.2 Critical medicines[4,5] needed by people are accessed and continued during and outside healthcare and pharmacy core hours:

- Services are modelled to maximise people's access to medicines during initial hours following admission (e.g. first night medications) to enable the continuation of current critical medicines or initiate medicines if necessary
- Specific medicines, agreed locally based on need are held in stock for people to use as initial supplies of urgent medicines
- Prescription forms e.g. *FP10s* are available and used by prescribers to access urgent medicines not held on-site
- Mechanisms are in place for empowering non-prescribers to supply urgent medicines via *Patient Group Directions (PGDs)* or local protocols in line with legislative requirements

1.3 Mechanisms are in place to enable the prompt identification of non UK medicines.

1.4 *Medicines reconciliation* is completed in line with national guidance[6]. The outcomes of the *medicines reconciliation* are used to inform clinical care.

1.5 Initial use of patient own drugs, prescribing and supply of medicines to people takes account of the standards described throughout this publication.

STANDARD 2: PEOPLE ARE ABLE TO KEEP THEIR MEDICINES AND SELF-ADMINISTER THEM SAFELY

2.1 An *in-possession* policy is in place which:

- Encourages people to keep their medicines and self-administer them, unless they are unable to do so due to physical, vulnerability or mental health risks
- Identifies any specific medicines that are excluded as full *in-possession* and are supplied under supervision (not in-possession) or a reduced quantity of possession (e.g. weekly *in-possession*)
- Excludes Schedule 2, 3 and 4 *Controlled Drugs* as *in-possession*. These are supplied under supervision unless in exceptional circumstances on an individual case basis
- Requires that people have a review of their suitability for keeping their medicines as part of ongoing review of their care, or if a risk to their safety is identified during their stay.
- Is shared with all healthcare staff and implemented by them within the medicines pathway
- Requires provision of information to people about the basis of the local policy and how this is used to individualise their care and safety and optimise use of medicines.

2.2 People are assessed for their suitability for keeping their medicines using approved *in-possession* risk assessment tools that result in:

4 NPSA 2010 Reducing harm from omitted and delayed medicines in hospital.
5 Specialist Pharmacy Service 2016 NPSA Rapid Response Report: Reducing harm from missed or omitted and delayed medicines in hospital. A tool to support local implementation.
6 NICE 2015 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.

2.2.1 An initial assessment within 24 hours of admission enabling continued access to medicines

2.2.2 Continuation of the *in-possession* status for a person who is transferred from one secure environment to another unless this needs to be reviewed for safety reasons

2.2.3 Subsequent completion/review of a comprehensive *in-possession* risk assessment within 7 days of admission or transfer if needed.

2.3 Medicines brought into the secure environment by people are:

- Accessed where possible, encouraging people to bring medicines from home or other care setting on admission
- Used to inform the initial medication history and *medicines reconciliation*
- Are assessed as suitable and are used to continue people's access to the medicine if clinically appropriate
- Destroyed if not needed with patient consent and assurance that medicines to meet their needs will be provided during their stay.

STANDARD 3: PEOPLE RECEIVE SUPPORT TO SELF-ADMINISTER AND ADHERE TO THEIR MEDICINES

3.1 People receive or are referred for additional services and support for taking medicines as part of the reception screening and as the need is identified during their stay.

3.2 Information provided to people, written and verbal, is in a format or language they need based on their physical, mental health, understanding of the English language and literacy.

3.3 People are given information about how they can access medicines in the secure environment via healthcare or other areas (for example a shop or other retail mechanism) – See Box 1 below.

Box 1: Good Practice Point:

Examples of support could include:

- Provision of a booklet that describes healthcare access which includes access to medicines (*over-the-counter*, repeat prescriptions etc.)
- provision of a compact that explains how medicines should be used safely and how medicines are accessed in the secure environment
- provision of monitored dosage systems[7] (where appropriate) to encourage self-administration
- shorter possession quantities
- medicines reminder charts
- information resources in different languages or font sizes.

7 RPS guidance Improving patient outcomes through the better use of multicompartment compliance aids (MCAs).

DOMAIN 2: MEETING PEOPLE'S MEDICINE NEEDS DURING THEIR STAY

The standards in this domain are based on *supported self-care* as a key principle with services to support this throughout a person's care in the secure environment. It includes medical devices and appliances as well as medicines. As self-care is a key principle in healthcare, *over-the-counter* and access to medicines without a prescription for self-limiting or minor ailments is included first followed by prescribed medicines. The aim of these standards is the integration of the medicines pathway and pharmacy services (both *dispensing* services and bulk stock supply) with clinical pharmacy provision underpinned by strong partnership working with other healthcare and security staff to enable the safe supply and administration of medicines.

STANDARD 4: PEOPLE ARE ABLE TO SELF-MANAGE THEIR HEALTH AND THEIR MEDICINES-TAKING

4.1 People can purchase *over-the-counter* medicines that are not appropriate for supply on the NHS and would have been purchased in the community from a locally agreed list (e.g. herbal remedies, skin/scalp preparations for cosmetic purposes, vitamin supplements, simple analgesia, indigestion remedies, etc.).

4.2 People can access a range of medicines through healthcare via agreed protocols for non-prescription medicines used for minor ailments. Medicines may be administered at the time of consultation, or a supply may be made for later self-administration. Administration or supplies via healthcare are recorded as part of the person's clinical record and people are referred for additional clinical care if needed. Any medicines supplied for later self-administration must be supplied in the manufacturer's original packs and without additional labels.

4.3 People can store medicines safely with individual lockable secure storage available in shared accommodation. This storage facility may be used for other personal items as well as medicines but must meet minimum standards for medicines storage (see also standard 19)[8].

STANDARD 5: PEOPLE WITH LONG TERM HEALTH NEEDS CAN SELF-MANAGE THEIR MEDICINES SUPPORTED BY THE HEALTHCARE TEAM

5.1 People self-administering medicines are able to request repeat prescriptions themselves using local processes.

5.2 People receiving care for long term conditions are given information about their medicines as part of their care pathway.

5.3 People can see a pharmacist or pharmacy technician at the secure environment to discuss their medicines and receive support they need to optimise their care.

STANDARD 6: PEOPLE HAVE THE RIGHT MEDICINES PRESCRIBED FOR THEM SAFELY

6.1 People can access prescriptions for acute and long term conditions in a timely and legal manner.

6.2 Prescribers may not issue private prescriptions, unless the item is not available on the NHS. Where private prescriptions are issued, the person must pay for the medicines supplied and any administration charges agreed by the prescriber and/or dispensing pharmacy.

8 Safe and secure handling of medicines (March 2005).

6.3 People are prescribed medicines by medical and non-medical prescribers competent to prescribe for the condition they are being treated for[9,10].

6.4 People have their allergy status on medicines recorded, checked and used to prescribe new medicines safely.

6.5 All prescribers use the *health and justice information system* to prescribe and print prescriptions. This includes in-reach prescribers (e.g. mental health, dental, substance misuse clinicians) who should also prescribe directly for people and not delegate this to another prescriber when initiating or adjusting medicines.

6.6 Prescribed medicines have a documented indication recorded in the person's record that simplifies clinical monitoring or audit and continuity of care.

6.7 Prescribers include the possession status of the medicine on the prescription based on the person's individual risk assessment and local *in-possession* policy (see Standard 2).

6.8 People receive prescriptions that utilise the national customised prescription form for routine day to day prescribing. *FP10 prescriptions* are only used for urgent medicines (i.e. medicines cannot be dispensed by the usual pharmacy) or where a person is released and there's not enough time to organise a supply of medicines from the usual pharmacy.

6.9 Prescriptions are usually written for up to a month's supply or a single pack with a documented review date (see also Standard 7).

6.10 People receive medicines that are evidence based and clinically appropriate for their needs using a locally agreed formulary[11,12].

6.11 The choice of medicines in the local formulary is ratified via the medicines management committee (see Standard 15) .The formulary is based on or takes account of:

- Formularies for primary care prescribed medicines used by local primary care services
- National formularies for secure environments
- Specialist provider formularies for in-reach specialist care (for example specialist mental health, dental, substance misuse prescribers)
- NHS England commissioning policies and local agreements for shared care and hospital only prescribing that includes clear monitoring responsibilities for the prescribed medicine(s)
- Selection of specific formulations for medicines that pose a high risk of diversion or harm.

6.12 People receive individualised care using non-formulary medicines via a local exceptional case process which is fully documented in the person's clinical record.

6.13 People in secure environments access Payment by Results (PbR)[13] excluded medicines the same way as people in the community.

6.14 Prescribing responsibility for specialist medicines is retained by the specialist prescriber (for example secondary care clinician, dentists) in line with national, local shared care and primary care policies.

6.15 Pharmaceutical specials are only used in exceptional cases and where a licensed alternative is not appropriate. Specials should be sourced to minimise the costs to the NHS[14].

6.16 People who access medicines via external prescribers (e.g. hospital prescribers) have this medicine documented within their clinical record in the secure environment. This is used to ensure continuity of access to the medicine and safe prescribing of concurrent medicines.

9 GMC 2013: Good practice in prescribing and managing medicines and devices.
10 RPS 2016: Prescribing competency framework.
11 NICE Medicines Practice Guidelines: (MPG1), Feb 2014 Developing and updating local formularies.
12 RCGP 2011 Safer Prescribing Prisons.
13 PbR excluded medicines are a list of medicines that are excluded from the NHS National Payment system and funded via separate arrangements. Further information is at: NHS Payment system.
14 RPS 2016: Pharmacy Practice Resource – Specials.

STANDARD 7: PEOPLE HAVE REPEAT PRESCRIPTIONS WRITTEN SAFELY AND CONTINUALLY

7.1 People needing repeat prescriptions are able to access them using local processes, aligned with those used in primary care, that minimise missed doses of medicines.

7.2 The use of repeat templates and the process of repeat prescribing follows a locally agreed procedure that implements best practice[15,16].

7.3 People are able to receive a specific number of repeat prescriptions or there is a specific date after which a clinical review is provided before further prescriptions are issued for the repeat medicines. Periods between clinical reviews will usually be no more than 6 months.

7.4 Where people have a medicine fully *in-possession*, they are able to order their repeat prescription themselves.

7.5 Where one or more medicines are held not in possession, systems are in place to ensure timely ordering and supply of these medicines.

7.6 People who fail to request, collect repeat medicines or request repeat medicines too frequently are identified and offered support to help them self-manage their medicines and referred for a *medication review* if necessary.

7.7 Repeatable dispensing using the national customised prescription form to enable up to 6 months of a medicine to be supplied in instalments via "batch" prescriptions can be used via local arrangements but using the community pharmacy service specification and guidance as the basis for the service[10].

STANDARD 8: PEOPLE HAVE THEIR MEDICINES REVIEWED EFFECTIVELY

8.1 People have a clinical *medication review* included in their care plan based on:

- Their individual clinical needs, current prescribed medicines and additional information about their day to day activities relevant to their clinical outcomes
- national clinical guidelines
- local care pathways and procedures
- therapeutic drug monitoring needed for specific medicines.

8.2 People have a clinical *medication review* that aligns with their individual needs, is clearly for one or more of their medicines, with the review conducted in line with national guidance[16].

8.3 People are able to have a *Medicines Use Review* or access a *New Medicines Service* that are equivalent to the services available via community pharmacies. Local arrangements exist to identify people and offer these services to people that would benefit them and enable people to self-refer for them. In secure settings, appropriately trained registered pharmacy technicians may provide these services.

8.4 The completion and outcomes from the review is clearly documented in the person's clinical record and care plan. Read coding of the review should facilitate audit and clinical monitoring of people's care.

15 PSNC 2015: Repeat Dispensing.
16 NICE Guideline NG5 2015: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.

STANDARD 9: PEOPLE'S MEDICINES ARE DISPENSED AND SUPPLIED BY EFFECTIVE AND RESPONSIVE PHARMACEUTICAL SERVICES

9.1 Contracted pharmacy services comply with all relevant regulatory, best practice standards and align with national and local service specifications (i.e. Community Pharmacy Essential and Advanced Services; NHS England health and justice commissioned services).

9.2 People have access to an on-site pharmacy where this is specifically included in the NHS England service specification for the secure environment.

9.3 People receive a responsive pharmacy service that:

- Receives prescriptions each day Monday to Friday with additional routine receipt on Saturdays, Sundays and Bank Holidays if the pharmacy is open
- Delivers repeat dispensed medicines and routine bulk stock orders usually within 48 hours (up to 96 hours over bank holidays) of the prescriptions/orders being received including a delivery on Saturdays if needed
- Provides clear information, with regular updates in the event that all or part of the medicine/prescription cannot be supplied with support to enable the clinician and the person to make alternative arrangements or choices of access or treatment
- Dispenses and delivers acute/urgent prescriptions ideally on the same day, but as a minimum within 24 hours. Arrangements must be in place for use of alternative pharmacies when the contracted pharmacy is closed
- Aligns the timing of prescription/order receipt and delivery with the clinical services being delivered to people and operational requirements in the secure environment
- Provides medicines in suitable containers that meet national guidance and meet the additional needs of people such as monitored dosage systems, specific labelling and language needs.

9.4 People are able to access urgent medicines when the contracted pharmacy is closed via local out of hours arrangements (see also Standard 1).

STANDARD 10: PEOPLE RECEIVE A CLINICAL PHARMACY SERVICE THAT SUPPORTS THEM IN OPTIMISING THE OUTCOMES FROM THEIR MEDICINES

10.1 People and the healthcare team have access to on-site pharmacist and pharmacy workforce that delivers a pharmacist-led, clinically and safety focussed service (see Standard 22).

10.2 Local arrangements provide the basis for the on-site support using directly employed pharmacy staff or using contracted staff.

10.3 The roles of the on-site pharmacy team are based on people's needs and may include:

- Directly supplying/administering medicines and advising people about their medicines
- Provision of *medicines use reviews* and *new medicines services*
- Provision of public health and well-being services
- Providing expertise in practical therapeutics, medication safety and delivering training for the healthcare team
- Establishing ongoing professional relationships with individual people receiving medicines and the healthcare teams and secure environment staff
- Facilitating communication and liaising across a person's care pathway (including the wider primary care workforce, secondary care, social care and domiciliary environments)
- Supporting people with long term conditions such as "difficult" hypertension, compliance with lipid-lowering therapy or mental health medicines in partnership with other clinicians
- Supporting or managing repeat prescribing processes
- Supporting the implementation of *in-possession* policies and processes
- Offering a holistic approach to the use and understanding of medicines by patients that includes step up and step down management required in long term conditions, including mental health and pain management

- Facilitating access to medicines (e.g. arranging secondary care medicines, "specials", unusual formulations etc.)
- Interpreting national and local commissioning decisions as they relate to medicines and use by people
- Identifying opportunities for savings and efficiencies where that does not conflict with the interests of individual people
- Supporting the design of medicines pathways that integrate operational safety of medicines alongside clinical care pathways
- Specialist analysis of audits and support governance processes within the service.

STANDARD 11: PEOPLE RECEIVE THEIR MEDICINES IN A SAFE, TIMELY WAY

11.1 People are able to receive medicines in a medical emergency in line with legislation and national guidance[17].

11.2 People receive medicines via contingency arrangements in the event of:

- A security in the prison or enforced lock down that covers a period where people would collect their medicines
- An infection control incident such as a seasonal outbreak or pandemic flu.

11.3 People have not in-possession medicines supplied and administered to them by registered healthcare professionals and an additional witness where necessary and as defined locally (e.g. for *Controlled Drugs*).

11.4 People have in possession medicines supplied to them by a competent member of healthcare or pharmacy staff who has access to a registered healthcare professional within the site at the time the supply is made.

11.5 People are supplied with, or receive medicines from, individually dispensed and labelled prescriptions or over-labelled supplies when they receive a medicine via a *patient group direction* or supply against a prescription. Administration of doses from bulk stock is reserved for urgent, short-term supply and for specific *Controlled Drugs* (see Standard 18). *Secondary dispensing* is not allowed.

11.6 People will only receive medicines via verbal order under exceptional circumstances (and never for Schedule 2 and 3 *Controlled Drugs*) where provision of a written or electronic prescription is not possible and failure to supply or administer the medicine would be harmful. Where verbal orders are used:

- A formal procedure is in place to ensure that the verbal order is given by a prescriber, and received, recorded and acted on by a registered healthcare professional
- The procedure will specify the duration for which a verbal order will apply, and the process for obtaining written confirmation of the prescriber's verbal instructions
- The procedure will cover other methods of receiving remote instructions such as fax or secure email.

11.6 People receive medicines via best practice procedures that meet legislative and professional standards for the supply and administration of medicines. If a medicine is not administered or supplied for clinical reasons, the person is informed of the reason, is referred for a clinical assessment and a record made in the patient record of the reasons for non-administration or supply.

11.7 People that need to start a new medicine within 24 hours of their clinical assessment or issued prescription are able to access the medicine within this time frame via on-site stock (bulk stock or over-labelled) or via local arrangements for accessing urgent medicines e.g. via pharmacy emergency supply or out of hour services.

11.8 People can always access *Medicines Administration Points (MAPs)* for medicines:

- At times that enable them to take their medicines at the right time for the dose regime they have

17 Resuscitation Council UK 2015: Resuscitation guidelines.

- Under the supervision of security staff to make sure they are able to receive their medicine safely. This is essential for doses that are supplied under supervised consumption (i.e. not-in possession doses)
- From MAPs that are fit for purpose for medicines storage[18,19,20], effective identification of people collecting medicines and the safety features needed to administer and supply medicines/ doses safely, whilst retaining confidentiality (e.g. sufficiently large hatch sizes to observe oral administration; separation of the person collecting the medicine from other people waiting for their medicines)
- That has IT available to electronically record the administration or the supply of the medicine. Administration via a paper record is only available via areas agreed with the commissioner and are recorded onto the IT system promptly after the medicine has been given or supplied.

11.9 People are able to receive individual doses of medicines under supervision with clear information about how this supervision will be undertaken. This includes clear roles and responsibilities for:

- The person to take the dose in line with the safe processes they have been informed of and have consented to
- The healthcare team who administer supervised doses within agreed procedures that meet national professional expectations (see box 2)
- Security staff that support the healthcare team by managing the people waiting for their medicines: to maintain the confidentiality of the person collecting medicines; identifying and acting on diversion of medicines during and after the person has been given their medicine and supporting the healthcare staff when an incident occurs with a person collecting their medicine.

11.10 When people fail to collect supervised doses there is a process in place that results in the person:

- being contacted to receive the dose of critical medicines
- being referred for clinical review in the event that 3 or more doses have been missed with further doses being withheld unless further supply is authorised by a prescriber.

11.11 When a person fails to collect *in-possession medication* there is a process in place to identify these people and to follow up their adherence and well-being and refer them for further clinical review as needed.

11.12 When a person receives a medicine that is not in an original pack alternative arrangements are used to ensure people can receive a copy of the manufacturer's patient information leaflet.

Box 2: Good Practice Point: Meeting national professional expectations on administering supervised doses.

This includes the following:

- Using clear processes for observing and minimising the risk of diversion
- Provision and consumption of approx. 200ml of water by the person taking the dose
- Examining the oral cavity visually but not physically before and/or after the dose has been taken for specific medicines named in the in-possession policy.

18 RPS 2015: The safe and secure handling of medicines – a team approach.
19 NPSA 2007: Design for patient safety: a guide to the design of the dispensing environment.
20 DH 2014: DH Health building notes.

DOMAIN 3: PEOPLE CAN CONTINUE TO TAKE THEIR MEDICINES IF THEY ARE RELEASED OR TRANSFERRED ELSEWHERE

These standards describe how people continue to access their medicines safely and promptly as they move within (including during transit for critical doses of medicines) or leave detention (with supplies accessible for a minimum of 7 days post release, whatever their destination). The principles and recommendations that underpin the standards are RPS[21] and NICE guidance[11]. The standards apply to all medicines including *Controlled Drugs* and thus all secure environments should accept people who are taking any medicine.

Partnership working between clinicians within and between sending and receiving care settings, and between custodial and healthcare/pharmacy teams is essential to provide a seamless and safe transition of medicines optimisation.

STANDARD 12: PEOPLE HAVE ACCESS TO A SUPPLY OF MEDICINES ONCE THEY LEAVE

12.1 People have sufficient medicines and dressings, in dispensed packs (including *Controlled Drugs*) when they are released (into the community or for deportation) or transferred to another health and justice setting, including *Approved Premises*. This ensures continuity of care and safety, until the person can reasonably be expected to visit a community GP or arrives at their destination if deported from the UK. This supply will be for a minimum of 7 days and usually a maximum of a month's supply.

12.2 People can receive substance misuse medication and other not-in possession doses of "once daily" medicines before they leave to maximise the time available before their next dose.

12.3 Where the transfer or release date is known in advance, people should:

- Receive information about their medicines before they leave to support them in being able to continue to take their medicines
- Have ongoing care provision in place for when they leave if released into the community for specialist care or substance misuse services or individual needs to support safe medicines adherence
- For people leaving the UK, checks are completed to confirm the legal status of each medicine in the destination country.

12.4 Where the release into the community is unplanned, people are given or can access *FP10/ FP10MDA prescriptions* so they can access their medicines via a community pharmacy.

12.5 People who need doses of critical medicines during transit or in court are able to access these doses.

12.6 Medicines that are not needed during transit are stored safely within the person's property with a clear audit trail where responsibility for safe and secure storage is passed between healthcare and transport organisations.

21 RPS 2012: Keeping patients safe when they transfer between care providers – Getting the medicines right.

STANDARD 13: PEOPLE ARE GIVEN WRITTEN INFORMATION ABOUT THEIR MEDICINES THAT IS ALSO USED TO INFORM THEIR ONGOING MEDICINES NEEDS

13.1 People are given a discharge summary on release or transfer that provides information about their ongoing needs for medicines (See Box 3).

13.2 The discharge summary should be available to the person and clinicians taking on the care of the person ideally at the time of, and certainly within 24 hours of, them leaving. The summary should be shared in the most effective and secure way, such as by secure electronic communication, a paper copy for the person. It needs to recognise that more than one approach may be needed.

13.3 People who are transferred for hospital treatment should have a summary of the current prescribed and other relevant medicines needs included in the shared clinical information.

Box 3: Good Practice Point: Discharge summaries should include:

- Contact details of the person and contact details of the current healthcare leads in the event of any queries after they have left
- Details of other relevant contacts identified by the person and their family members or carers where appropriate – for example, their nominated community pharmacy for people released into the community
- Known drug allergies[22] and reactions to medicines or their ingredients, and the type of reaction experienced (see the NICE guideline on drug allergy)
- Details of the medicines the person is currently taking (including prescribed, over-the-counter medicines). Details could include name, strength, form, dose, timing, frequency and duration, how the medicines are taken and what they are being taken for
- Changes to medicines, including medicines started or stopped, or dosage changes, and reason(s) for the change
- Date and time of the last dose, such as for weekly or monthly medicines, including injections
- What information has been given to the person, and their family members or carers
- Details of any specialist medicines and appliances including medicines supplied via homecare
- Where appropriate any other information needed – for example, when the medicines should be stopped or reviewed, ongoing monitoring needs and any support the person needs to carry on taking the medicine safely.

Adapted from NICE NG 511

22 NICE Guideline CG183 September 2014 Drug allergy: diagnosis and management.

DOMAIN 4: PEOPLE HAVE THEIR MEDICINES OPTIMISED WITHIN A ROBUST CLINICAL GOVERNANCE FRAMEWORK

People staying in secure environments for a day or for years will only receive the standards within Domains 1-3 if the services they receive to optimise their medicines are underpinned by a robust clinical and operational framework of governance. This framework encompasses the entire medicines pathway[13] to ensure safe handling and storage of medicines and a positive culture of reporting and learning from medication incidents.

STANDARD 14: OVERALL MEDICINES GOVERNANCE AND ACHIEVEMENT OF THESE STANDARDS IS LED BY A SENIOR PHARMACIST

14.1 Pharmaceutical advice and leadership may be from an employed pharmacist or through an agreement with an organisation or individual.

14.2 Prescribing advice may only be given by a pharmacy professional or prescriber and be in line with national and local policies and guidelines. Advice provided by all healthcare professionals e.g. nurse practitioners, nurses, dieticians, physiotherapists and others must be within agreed local guidelines and any recommendations to patients or other clinicians that may affect prescribing should be within these parameters.

STANDARD 15: A FORMAL ARRANGEMENT IS IN PLACE FOR DEVELOPMENT OF THE INFRASTRUCTURE TO SUPPORT SAFE MEDICINES HANDLING AND USE.

15.1 A functioning medicines management committee (MMC) meets with Terms of Reference and specific accountabilities to the local internal governance structure and external commissioning partnership board or equivalent. The MMC should include input from: a pharmaceutical adviser or supplying pharmacist; clinical staff involved in general, mental health care including prescribers; staff involved in security and non-healthcare operations. In larger organisations, local medicines management groups may operate with accountability to an overarching MMC.

15.2 A named local lead, who operationally is accountable and responsible for the day to day delivery of the medicines governance infrastructure.

15.3 An overarching medicines policy or code that describes the principles or basis on which medicines (including unlicensed medicines) are used and handled within the organisation. This policy should be underpinned and operationalised by formularies, procedures and additional policies relevant to these standards.

15.4 People receiving medicines are able to influence and share their experiences which inform medicines policies and procedures.

15.5 People have administered or receive a supply of medicines via *Patient Group Directions (PGD)* when:

- A patient specific direction cannot be used for effective access to care
- The organisational medicines policy includes the basis for *PGD* development and use
- Legal and best practice arrangements are used for the development, authorisation and use of the *PGD*
- Where a supply is made, people receive a labelled supply of the medicine they take away with them in line with regulatory and best practice
- The administration or supply is recorded in the clinical record.

15.6 People are administered or receive a supply of medicines (e.g. *over-the-counter* medicines or directly administered medicines) via protocols that are formally developed to include information to ensure safe supply and appropriate referral.

STANDARD 16: STANDARD OPERATING PROCEDURES (SOPS) ARE IN PLACE FOR THE MEDICINES PATHWAY

16.1 The organisation's medicines policy and/or codes describes how SOPs are integrated into a system of safe medicines use across and within the organisation.

16.2 People access medicines and staff handle medicines according to procedures that:

- Cover the full medicines pathway so that medicines are handled consistently by clinical and operational staff
- Take into account specific national operational policies relevant to secure environments (e.g. Home Office and NOMS publications)
- Are ratified by the MMC and are signed up to by all staff who deliver the procedures within the scope of the SOPs
- Will indicate who is authorised to carry out each activity, be signed by staff using it and indicate what training is necessary, and what records will be kept
- Are audited to assure people and the organisation that medicines are being handled safely.

16.3 Codes and SOPs are reviewed at least every 2 years, or more frequently when procedures or legislation changes or as a result of learning from a safety incident.

STANDARD 17: PEOPLE RECEIVE MEDICINES FROM AN ORGANISATION THAT HAS A MEDICATION SAFETY CULTURE

17.1 There is a medication safety officer (MSO) or medication safety lead for each organisation delivering healthcare services to people[23]. The MSO or medication safety lead is linked into and contributes to the national or local MSO and other medicines safety networks.

17.2 When there is a medication incident, whether this is a near miss or is identified after the person receives the medicine, the incident should be formally reported in line with:

- National guidance[24] and the requirement to report incidents to the National Reporting and Learning System
- Local reporting strategy (i.e. what to report) and reporting mechanisms that include escalation of the incidents within the organisation and to NHS England commissioners in line with current national and local requirements
- Shared reporting arrangements between healthcare and other teams within the secure environment.

17.3 Medication safety incidents should undergo a root cause analysis with subsequent learning, adaptation of procedures and evaluation of changed processes to minimise the risk of similar incidents.

23 RPS,2016, Professional standards for the reporting, learning, sharing, taking action and review of incidents.
24 NHS England March 2014: Patient safety alert to improve reporting and learning of and medical devices incidents.

17.4 People who have experienced a medication error are informed, apologised to, and appraised of any action being taken to rectify the error.

17.5 Learning from medication errors and systems failures related to medicines is shared with the multidisciplinary team and the whole organisation if appropriate, and acted upon to improve practice and safety.

17.6 People who have suspected adverse reactions to medicines, particularly new medicines under intensive monitoring, should be reported to the MHRA by anyone including non-clinical staff and patients. Reports can be made online at www.yellowcard.gov.uk

17.7 Security incidents related to medicines that are identified or reported by security staff should be shared with the healthcare team. This enables clinical consequences of the incident for the person to be followed up.

17.8 Medication incidents should be collated and reported to the MMC, who can identify incident trends and oversee the handling of the incidents.

17.9 A process is implemented for receiving, acknowledging and acting on medicines safety alerts, including drug recalls, whether national or local.

STANDARD 18: CONTROLLED DRUGS (CD) ARE HANDLED LEGALLY AND SAFELY

18.1 *Controlled Drugs* legislation (including licensing) is implemented and good practice as described by CQC, NICE and related publications is used to prescribe and manage CDs.

18.2 Partnership between security teams and healthcare teams is actively demonstrated to develop collaborative procedures for CDs.

18.3 Where a CD Accountable Officer (CDAO) is not legally required, there will be a nominated lead who is responsible for the handling of CDs in the same way as a CDAO.

18.4 CDAOs and CD leads will, within the framework of the NHS England CD Local Intelligence Network (CD LIN), share intelligence, information and complete self-assessments regarding the management of CDs. NHS England CDAOs will also be allowed to access the site to fulfil their duties as a CDAO.

18.5 SOPs are in place to cover as a minimum:

- Who has access to CDs
- Where CDs are stored
- Security, including transporting CDs within the secure environment
- Disposal and destruction for stock and patient's own CDs as required within legislation and local CDAO arrangements
- Who should be alerted if complications or concerns arise including when and how to report CD incidents
- Record keeping including CD Register and record of patient returned CDs.

18.6 Transporting of CDs within the site requires additional safeguards, such as a radio for prompt reporting of a CD incident during transit and agreed times when CDs can be transported safely.

18.7 Where more than one provider deliver services that include the prescribing or use of stock CDs (Schedule 2-5) providers must ensure there is a clear delineation of ownership, accountability and handling of CDs between their organisations. For example where a second provider requisitions and supplies CDs this provider will need the relevant licences and will need to record CD transactions in a separate CD register to the one held by the main healthcare provider.

18.8 Requisitions for CDs can be completed using an in-house order form or the national CD requisition form. The requisition must be counter-signed by a doctor or pharmacist as required by the Misuse of Drugs Act 1971 and associated guidance.

18.9 Transfer of CDs from one area of the secure environment for storage in another should be undertaken using a written internal order form and receipt in the recorded.

18.10 FP10PCD form does not need to be used for Controlled Drug prescriptions written within secure environments. This is because the are commissioned by the NHS are considered NHS prescriptions. This includes circumstances where pharmaceutical services to support the provision of NHS healthcare to secure environments are commissioned from community pharmacies.

18.11 At least one registered healthcare professional should be responsible for administration and a second suitable person should be present to witness and countersign administration and also to countersign the *Controlled Drugs* register.

18.12 Local policies specify the competencies required for the second person witnessing the administration to ensure they are aware of the relevant legislation and best practice guidance.

18.13 People must receive CDs (Schedule 2-4) under supervision except under exceptional circumstances agreed by the MMC. Methadone and buprenorphine should normally be administered from bulk stock supplies if 10 or more people are receiving these medicines. This is to minimise the risks of selection error if individually named supplies were used. For other CDs, named supplies should be provided (see Standard 11).

18.14 Prescriptions for people receiving CDs from stock should be clinically checked by a pharmacist to ensure that the CD and any concurrent medicines are safe for the person to take.

18.15 Administration of liquid medicines such as methadone oral solution 1mg/ml to a number of people (>10 from one MAP) on a regular basis should be risk assessed and will usually be undertaken via an automated pump or a computerised pump system.

18.16 People prescribed CDs (Schedule 2 and 3) will not have their supply of CDs interrupted on transfer to another custodial setting. To achieve this:

- A copy of the original Schedule 2 or 3 CD prescription showing the handwritten signature of the prescriber is sent to the receiving custodial setting (in electronic or paper format)
- A supply of the CD (if this is not held as stock in the receiving custodial site) is sent together with information on the recent administration history of the CD to the patient.

18.17 As with other medicines people being released, transferred or deported should have access to at least 7 days' supply of their CD as they leave (see Standard 12).

STANDARD 19: PEOPLE RECEIVE MEDICINES THAT ARE STORED SAFELY AND SECURELY

19.1 Medicines storage should be in line with national guidance and regulatory requirements. Audit trails and governance processes are in place to underpin the supply and storage of medicines.

19.2 Security and access to keys, during and outside of healthcare/pharmacy working hours, for general medicines storage and *Controlled Drugs* is robust and underpinned by SOPs.

19.3 Refrigerators should be used for the sole purpose of medicines storage and be checked regularly, underpinned by SOPs that detail the action to take should the fridge temperatures deviate from those required.

19.4 Arrangements for medication storage in a person's accommodation rests with the secure environment estate. Consideration should be given to the need for lockable storage for medicines in shared accommodation fit for this purpose. This lockable storage may be used for other personal items and not restricted just to medicines.

19.5 Medical gases are appropriately stored, in line with Control of Substances Hazardous to Health (COSHH) information and advice is accessible in the healthcare centre.

19.6 People's named medicines awaiting collection and medicines stock (including medicines in emergency bags) are regularly checked to enable:

- Expired stock to be removed, destroyed and replaced
- Uncollected named medicines to be removed if no longer needed or followed up in line with omitted doses/adherence monitoring

- Storage facilities to be maintained in an orderly fashion to minimise medication errors.

STANDARD 20: PEOPLE RECEIVE MEDICINES WHERE CARE IS MONITORED AND AUDITED

20.1 Audits are conducted to assure the delivery of safe clinical and operational practices. (See Box 4 for examples).

20.2 People who are taking high risk medicines (clinical and at risk of diversion or trading) expect to, and have, their adherence checked for medicines they have in their possession. This is completed in partnership with the person and security teams, within organisational and national rules and with clear procedures for acting on any non-adherence identified.

20.3 Prescribing analysis is routinely conducted to support evidence-based practice, formulary use and inform people's clinical outcomes. Analysis is prioritised on national and local requirements with consideration given to:

- High risk medicines relating to substance misuse and diversion
- Medicines acting on the central nervous system
- Antimicrobial prescribing
- **NHS England's Medicines Optimisation Dashboard**.

20.4 Nationally required monitoring of care (e.g. Health and Justice Indicators of Performance –HJIPs) are reported in line with NHS England commissioner requirements.

Box 4 :Good Practice Point Examples of audits that may be conducted

- Audits against SOPs, including CDs
- Clinical audits to confirm the implementation of NICE or other national clinical guidelines and formularies
- Audits to confirm the implementation of *in-possession* policies, *medicines reconciliation* delivery and outcomes, omitted and delayed doses/medicines collection, repeat prescribing processes, medicines liable to misuse, audits required by commissioners.

STANDARD 21: PEOPLE HAVE THEIR CARE RECORDED AND COMMUNICATED EFFECTIVELY

21.1 National information governance guidelines are implemented with clear sharing of information when patient safety requires this.

21.2 The *Health and Justice Information System (HJIS)* is used to record when people are prescribed and supplied and administered medicines and when medicines are not collected/omitted.

21.3 The *HJIS* customised prescription format is used to print/issue prescriptions with *FP10 prescription* forms used for urgent medicines and unplanned releases only.

21.4 Electronic transfer of prescriptions (*FP10* and the customised prescription form) is used where this is legally possible.

21.5 Medicines are recorded consistently on *HJIS* by healthcare staff and in-reach clinicians so that:

- Summary Care Record use is maximised to support continuity of people's medicines on admission and on release into the community
- Prescribing processes are common for all prescribers
- Local and national templates and read codes are used to facilitate care planning, delivering the medicines pathway to people, audit and monitoring of outcomes
- On admission/transfer medication is reviewed and reconciled promptly
- Orders for dispensed and bulk stock are received onto *HJIS* to enable the supply/administration to be checked and recorded accurately by users
- People transferred to another secure environment experience a seamless transition of an accurate clinical record that enables continuity of their medicines
- A summary of their medicines needs is included in clinical information shared with external clinicians when people are released or are transferred to another type of care setting
- *HJIS* can be used to support monitoring of care including audit and actions needed as a result of local or national patient safety incidents and alerts.

DOMAIN 5: PEOPLE HAVE THEIR MEDICINES OPTIMISED BY A MULTIDISCIPLINARY AND COMPETENT WORKFORCE

The aim for this domain is that within secure environments there are multidisciplinary teams that have the right skill mix, capability and capacity to develop and provide safe, quality services to people. The standards apply across all professions and workforce roles with a principle that safe handling and medicines optimisation is everybody's business.

STANDARD 22: PEOPLE HAVE THEIR MEDICINES OPTIMISED WITH CONTRIBUTIONS AND LEADERSHIP FROM A COMPETENT PHARMACY WORKFORCE

22.1 A senior lead pharmacist is employed or commissioned to oversee and influence how medicines are clinically and operationally used.

22.2 Pharmacists and pharmacy technicians deliver on-site clinical and operational/governance duties as described in Standard 10 within the primary healthcare team which is made up of the required skill mix and competencies to deliver all clinical care people need.

22.3 Pharmacy technicians and pharmacy assistants provide the operational support to deliver non-clinical procedures relating to medicines. This releases nurses, pharmacists and clinically trained pharmacy technicians to provide clinical care.

22.4 The actual time spent by pharmacy staff on-site is locally determined and is influenced by:

- The people staying in the secure environment, their length of stay, the amount and type of medicines used based on their health needs
- Whether there is a dispensing pharmacy on-site
- The need for people to be able to access a pharmacist for advice about their medicines. Use of technology e.g. telephone, 'Skype', to provide remote consultation is encouraged to improve access to pharmacist advice, which is then not limited solely to time on site
- Details within the service specification and/or contract commissioned by NHS England for individual secure environments.

STANDARD 23: PEOPLE RECEIVE CARE FROM A WORKFORCE THAT HAS A CULTURE OF QUALITY IMPROVEMENT, LEARNING AND INNOVATION

23.1 Organisations review and improve the skills and skill mix of their teams to maximise the range of expertise for medicines optimisation.

23.2 Employing organisations enable staff to access training and networks that support staff in improving their skills and competencies in optimising medicines for people.

23.3 Organisations should encourage the training and recruitment of non-medical prescribers to broaden people's access to prescribers.

23.4 All staff with a role within the medicines pathway are aware of their own competency and deliver their roles within local and national policies/guidance and adhere to SOPs.

23.5 Employed staff have personal development plans that include their competency development and delivery of roles that involve medicines.

23.6 Policies are used to identify and manage team members who fail to reach minimum competency or performance standards. This includes taking action where staff are employed by another organisation who delivers care within the secure environment.

23.7 Planning is in place to ensure competency is maintained and developed to meet the changing service needs, improvements in people's care and the introduction of new technologies.

23.8 Induction training and information about the governance framework, clinical and operational procedures for medicines are used for staff when they begin working in the secure environment, this also includes short term locum/agency staff as well as employees.

APPENDIX 1: KEY REFERENCES

APPLICABLE FOR THE INTEGRATION OF MEDICINES IN ALL CARE PATHWAYS

1. Control of Substances Hazardous to Health (COSHH) Guidance
2. Current good practice guidance issued by organisations including RPS
3. GPhC
4. MHRA
5. DoH
6. Home Office
7. NPSA
8. Department of Health, 2010: Protocol for ordering, storing and handling vaccines
9. Environment Agency T28 – Sorting and Denaturing Controlled Drugs for Disposal
10. The Equality Act 2010
11. Good Practice in prescribing and managing medicines and devices (2013) – Guidance for Doctors
12. The Health Act 2006
13. Health and Social Care Act 2006
14. Human Medicines Regulations 2012
15. Medicines Act 1968
16. Misuse of Drugs Act 1971
17. Misuse of Drugs Regulations 2001
18. Misuse of Drugs (Safe Custody) Regulations 1973
19. National Institute for Health and Care Excellence (NICE), 2013: Patient Group Directions (NICE Good Practice Guidance)
20. National Institute for Health and Care Excellence (NICE), 2015: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes
21. National Institute for Health and Care Excellence (NICE), 2016: Controlled drugs: safe use and Management
22. National Institute for Health and Care Excellence (NICE), MPG1, updated 2014 Developing and updating local formularies
23. Nursing and Midwifery Council Standards for Medicines Management
24. Royal Pharmaceutical Society Medicines, Ethics and Practice
25. Royal Pharmaceutical Society of Great Britain (RPSGB) 2005: The Safe and Secure Handling of Medicines: a team approach

26. Royal Pharmaceutical Society (RPS), 2013: Medicines optimisation: helping patients to make the most of their medicines. Good practice guidance for healthcare professionals in England

27. Royal Pharmaceutical Society (RPS), 2016: A competency framework for all prescribers

FOR ON-SITE PHARMACY SERVICE PROVISION OR STANDARDS FOR EXTERNAL, SUBCONTRACTED PHARMACEUTICAL SERVICES

1. General Pharmaceutical Council (GPhC): Standards

2. Pharmaceutical Services Negotiating Committee (PSNC): Community Pharmacy Contractual Framework

3. Royal Pharmaceutical Society (RPS),2009: Good Dispensing Guidelines

4. Royal Pharmaceutical Society (RPS),2015: Professional Guidance on the Procurement and Supply of Pharmaceutical Specials

SECURE ENVIRONMENT HEALTHCARE SERVICE SPECIFIC PUBLICATIONS

1. Department of Health, 2006: Clinical Management of Drug Dependence in the Adult Prison Setting

2. Department of Health, national archive 2003: A Pharmacy Service for Prisoners

3. Ministry of Justice, 2010 : PSI IDTS 2010/45

4. National Prescribing Centre (NPC), 2005: Medication In-possession. A guide to improving practice in secure environments

5. NHS Business Services Authority (NHSBSA): Provision of FP10 and FP10[MDA] prescription forms by HM Prison Service for released prisoners

6. NHS England, 2014: Guidance on the management of tramadol in secure environments

7. NHS England, 2015: National Prison Pain management formulary

8. Public Health England (PHE), 2013: Management of Persistent Pain in Secure Environments

9. Royal College of General Practioners (RCGP), 2011: Safer Prescribing in Prisons

APPENDIX 2: GLOSSARY

Approved Premises (APs)
These are a distinct, non-custodial element of the National Offender Management Services (NOMS) estate providing accommodation with an enhanced level of supervision; they exist to protect the public and reduce reoffending. As such, APs provide a key element of the Probation Service's offender management arrangements. They have their legal basis in Section 13 of the Offender Management Act (2007).

APs main purpose is to provide supervised accommodation for high and very high-risk of harm offenders released from prison on licence. There are approximately 2200 residential places across the AP estate. The majority of the 100 APs serving England and Wales are for men only and are operated by the National Probation Service. Approximately 10% are owned and operated by not-for-profit organisations on behalf of NOMS.

Controlled Drugs (CDs)
These are specific medicines that are listed and controlled via the Misuse of Drugs Act (MDA) 1971 and associated regulations. The MDA 1971 and its Regulations control the availability of drugs that are considered sufficiently 'dangerous or otherwise harmful', with the potential for diversion and misuse. The drugs that are subject to the control of the MDA 1971, are listed in Schedule 2 of the Act and are termed CDs.

Dispensing
The preparation and labelling of medicines and appliances ordered on prescriptions, together with clinical screening against the person's other medicines and diagnoses, information and advice to the person, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

FP10/FP10MDA prescriptions
These are the English NHS prescription forms used by community GPs and dispensed by community pharmacies. In secure environments these forms are used to access urgent medicines that cannot be supplied via usual routes or are given to people who are released unplanned from the secure environment so they can get their medicines dispensed by a community pharmacy.

Health and Justice Information System (HJIS)
This is the electronic clinical record system commissioned by NHS England and deployed to all secure environments.

In-possession medication
This is medication that is supplied and self-administered by the patient, rather than not in-possession where each dose of a medicine is administered under supervision by a registered healthcare professional. In secure environments people undergo an assessment, reviewed as needed, to determine whether they are able to self-administer some or all of their medicines.

Medicines Administration Points (MAP)
This is a new term that describes the place where people receive or collect their medicines. This may be a single place within a secure environment or there may be several places where medicines are collected. The MAP is usually a room or secure area that ensures a safe and confidential experience between a healthcare professional and the patient.

Medicines reconciliation
Medicines reconciliation, as defined by the Institute for Healthcare Improvement, 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 term 'medicines' also includes appliances and over-the-counter or complementary medicines, and any discrepancies should be resolved. The medicines reconciliation process will vary depending on the care setting that the person has just moved into (NICE NG511).

Medication review
A structured, critical and clinical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste[11].

Medicines Use Review (MUR)

This is a structured review that is undertaken by a pharmacist or pharmacy technician to help patients to manage their medicines more effectively. MUR involves reviewing the patient's use of their medication, ensuring they understand how their medicines should be used and why they have been prescribed, identifying any problems and then, where necessary, providing feedback to the prescriber.

New Medicines Service

The service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence.

Over-the-counter (OTC) medicines

These are medicines sold, supplied or administered directly to a person without a prescription. There are two types of OTC medicines defined within the Human Medicines Regulations:

- General Sales List medicines- these can be sold or supplied by any person to another person
- Pharmacy medicines- these are sold or supplied to a person under the supervision of a pharmacist

In secure environments access to OTCs is usually led by healthcare with mechanisms of access agreed in partnership based on local arrangements.

Patient Group Direction (PGD)

PGDs provide a legal framework that allows the supply and/or administration of a specified medicine(s), by named, authorised, registered health professionals, to a pre-defined group of patients needing prophylaxis or treatment for a condition described in the PGD, without the need for a prescription or an instruction from a prescriber. Using a PGD is not a form of prescribing. See also NICE PGD Guidance.

Secondary dispensing

This is where a medicine labelled for a patient (i.e. already dispensed by a pharmacy against a prescription) is then taken out of the container, popped out into the patient's hand or into another container and then taken away by the patient to take later (i.e. in-possession). This is not good practice as supplied medicines need to be labelled in line with legislation or the dose administered immediately under the supervision of the nurse/ pharmacist/pharmacy tech.

Supported Self-care

People have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system- emphasise the requirement to use the term supported self-care.

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RPS TEAM

Rakhee Amin: Senior Professional Development Pharmacist

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CONSULTATION RESPONDENTS

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The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain.

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