Report of the Joint Sub-Committee on the Control of Dangerous Drugs and Poisons in Hospitals.

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MINISTRY OF HEALTH
CENTRAL HEALTH SERVICES COUNCIL

Report of the
Joint Sub-Committee on the

Control of Dangerous Drugs and Poisons in Hospitals

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Standing Medical, Nursing and Pharmaceutical Advisory Committees

Joint Sub-Committee on the Control of Dangerous Drugs and Poisons in Hospitals

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CENTRAL HEALTH SERVICES COUNCIL

Standing Medical, Nursing and Pharmaceutical Advisory Committees

Joint Sub-Committee on the Control of Dangerous Drugs and Poisons in Hospitals

REPORT

I. Introduction

1. We were appointed by our three parent Committees in 1955 to consider and report on a question which had been remitted by the Minister to the three Committees jointly:

"To consider and report on the desirability of adopting a standard system for determining the responsibility for the custody and issue of Dangerous Drugs and scheduled poisons in hospitals, and for recording the requisitioning and issuing of them".

2. We have met 20 times. As our examination of the subject developed we found that it was more intricate and of much wider significance than was at first apparent. We have received memoranda of evidence from the Association of Hospital Matrons; the Central Midwives Board; the General Nursing Council; the London County Council; the Pharmaceutical Society and the Guild of Public Pharmacists (jointly); the Royal College of Nursing and the Royal Medico-Psychological Association, and we have also heard oral evidence from a number of individuals. At our meetings we have had the assistance of representatives of the Home Office as well as of the Ministry of Health. Our special thanks are due to the pharmaceutical members of our Committee who produced detailed reports which were of great assistance to us. We also wish to record our appreciation of the work of our former Secretary Mrs. P. M. Williamson and of her successors Mr. A. L. Thompson and Miss M. E. Hammond who have responded to every call made on them.

3. In the last few years the Minister has three times been advised of the need for further consideration of certain aspects of the care of drugs: by the Central Health Services Council's Committee on Internal Administration of Hospitals; by the Standing Pharmaceutical Advisory Committee's Sub-Committee on the Hospital Pharmaceutical Service; and by the Standing Medical Advisory Committee's Sub-Committee on Injection of Wrong Solutions. We ourselves became convinced very early in our consideration that central guidance was indeed desirable on these questions.

4. The reason why the need is so acutely felt at the moment is largely historical. When many years before the introduction of the Health Service, legislation first

came to be made on the control of Dangerous Drugs and of poisons, the Home Office decided that the various Acts and Regulations should impose the very minimum of control on hospitals on the ground that the latter were responsible bodies and were better able than the Home Office to decide what system of restriction or control their different circumstances demanded. In 1935, for example, the Poisons Board stated:

"We would wish the rules that we recommend to be considered to represent the minimum precaution to be taken, it being contemplated that the authorities concerned will institute such additional control and supervision as the circumstances of the institution may require".

5. The discretion entrusted to hospital authorities has rarely been abused, and it is certainly no more likely to be today than in the past. But the number of drugs in common use has enormously increased and almost all forms of treatment are more elaborate. These changes affect not only medical and pharmaceutical staff, but must also be known to and put into practice by the nursing staff. The Committee have been much impressed with the elaborate precautions that the nursing staff must take and the difficulty of keeping the necessary records. These nursing responsibilities are greatly increased by the wide variety of procedures which nurses are expected to learn when they move from one hospital to another.

6. The National Health Service has introduced a new factor. The unifying of the Hospital Service, with common pay, common superannuation, and so on, has resulted in very much more frequent movement between hospitals of nurses and other staff. For a nurse to pass her whole career in one hospital, or even in one hospital group, is rather the exception than the rule. In these circumstances the advantages of a uniform system which once learnt need never be unlearnt, are obvious, and in many of the matters in which uniformity is most important—the labelling of drugs, for example—there are practically no countervailing arguments that can be based on variations in local needs. Our advice is, therefore, that it is unquestionably desirable to adopt "a standard system for determining the responsibility for the control and issue of Dangerous Drugs and scheduled poisons in hospitals, and for recording the requisitioning and issuing of them".

7. The remainder of our report indicates what we think the system should be, and we consider that if the system we recommend is adopted throughout the hospital service it would help to clarify the procedure for the nursing staff, benefit the patient and prevent leakages of Dangerous Drugs. These leakages are thought not to be extensive.

8. In the report we have included certain references to substances which are not Dangerous Drugs or scheduled poisons, and therefore are strictly outside our terms of reference. Our justification is that to have done otherwise would, in our view, not only have greatly reduced the usefulness of our advice but would in many cases have rendered it actually misleading.

9. We have not recommended any change in the Dangerous Drugs Regulations or Poisons Rules although owing to their complexity they are sometimes difficult to understand and apply, and in our view it would help if they could be simplified.

10. Throughout the report the term "Dangerous Drugs" is used in the sense defined in the Dangerous Drugs Act. For brevity we have in places used the

term "consultant" to include "senior hospital medical officer"; "matron" to include "chief male nurse"; "nurse" to include "midwife"; "sister" to include "charge male nurse" and "departmental sister"; "treatment sheet" to include bed card or case sheet on which prescriptions are written and treatment prescribed; and "ward" to include "department".

II. The Pharmacist and the Pharmaceutical Department

11. Responsibility for ward stocks. We are satisfied that the pharmacist must play a major part in promoting safety in the handling of poisons and Dangerous Drugs in the hospital. Normally he is the only person on the staff who has a detailed knowledge of the statutory requirements. He keeps abreast of amendments as they are made.

12. On the other hand we feel that his function should be almost entirely advisory and that he should not be asked to assume responsibility for the control of poisons and Dangerous Drugs once they have left his hands. We take this view because, as we understand the law, the pharmacist has few statutory duties with regard to poisons and Dangerous Drugs which do not apply equally to many other members of the hospital staff. We are aware that most hospitals have supplemented the statutory requirements by additional rules, and that in some hospitals the pharmacist is required to check the physical stock against a record of the doses given. While we are in agreement with the need for this check, we recommend that it should be the responsibility of the nursing staff. The ward sister, as a person legally authorised to possess and administer Dangerous Drugs, should be responsible for balancing her stock, and the matron as head of the nursing staff would be responsible for seeing that this is done, just as the chief pharmacist is responsible for the stock in his department.

The reasons for our recommendation are as follows:

(*a*) The check that a pharmacist can make is that of the arithmetic of the Dangerous Drugs record book: this is a limited check and it should not be thought that it has any other purpose. Even this however makes demands upon the pharmaceutical staff out of all proportion to its value.

(*b*) The Dangerous Drugs Regulations recognise the status and responsibility of a ward sister by vesting her with authority to be in possession of and to administer Dangerous Drugs. We believe that she should be encouraged to assume this responsibility to the full and that she would welcome it.

(*c*) If a further check is necessary the Matron has access to the wards and departments at any time and she has the means of checking the drug record book with other records, e.g. with the ward report books, which are not normally available to any other officer.

(*d*) The nursing chain of authority would be strengthened.

13. It would follow from this recommendation that, as part of her responsibility the ward sister would report an apparent discrepancy in her stock balance in accordance with the procedure recommended in Section VII. The losses of

poisons other than Dangerous Drugs may be less easy to discover. Nevertheless, if they are discovered they should be similarly reported.

14. The pharmacist will be able to give technical assistance in such investigations where necessary and we suggest that he should report to the matron unusual features which he may notice in the course of his dealings with wards and departments of which she has charge.

15. Inspection of ward cupboards. Under the Poisons Rules, ward poisons cupboards must be inspected at least every three months by a pharmacist or some other person appointed by the governing body. We recommend that this person should always be a pharmacist and that the matron should always be furnished with a report of his findings. We consider this routine inspection to be an important part of the pharmacist's duties. Not only can he ensure that the ward cupboards themselves are properly kept, but there is an opportunity for the sister to obtain advice on many matters concerning the drugs she has to store and administer, and generally for good relations between the ward and the pharmaceutical department to be fostered. We fully agree with the comments of the Linstead Committee on the value of a close relationship between the pharmacist and the ward sister, which we believe has a direct effect on the standard of care of drugs in the ward, and we think this inspection is important in maintaining such a relationship.

16. The Poisons Rules require only that all places where poisons are kept in the wards and departments should be inspected. In our view the pharmacist should check the condition of the cupboard itself and its locks, confirm that it is being used only for the types of drugs intended (though he cannot be expected to check that the actual contents of the bottles correspond with their labels) and at the same time, inspect the other medicine cupboards and give the sister any advice necessary on the proper storage or rejection of their contents. He cannot be expected to attempt a detailed check of the current level of Dangerous Drugs stocks against the Dangerous Drugs Record Book.

17. We would strongly endorse the advice of the Linstead Committee that no hospital should be entirely without the services of a pharmacist. Even if the pharmacist can only visit the hospital infrequently his visit can make a great difference to the standard of care exercised in the hospital, and when a problem does arise the hospital knows where to turn for advice. We believe that groups including both large and small hospitals have mostly already implemented the Linstead Committee's recommendations, by allowing the hospitals which already employ a pharmacist to act as "parents" in this respect to the smaller units. The groups which have lagged behind are those where none of the hospitals is large enough to have employed a pharmacist, and some of the mental and mental deficiency hospitals: we understand that in some cases the authority is ready to engage one but the difficulty is the shortage of applicants. Such groups will no doubt bear in mind the Linstead Committee's suggestion that in isolated districts a local retail pharmacist might be attached to the hospital.

18. Ordering. The first of the pharmacist's specific responsibilities is the ordering of drugs. We have been told in evidence that in some hospitals the Supplies Officer not only orders medicines, including poisons, but receives and stores them as well. This latter is a contravention of the Poisons Rules; the Supplies Officer may not store poisons nor order or store Dangerous Drugs. In view of

the many highly technical points which may be involved—for example the length of each substance's active life—we think that the purchasing of medicines and poisons should *always* be the responsibility of the pharmacist. This does not rule out the recording of transactions in the Supplies Officer's department, nor, of course, the Supplies Officer advising on the wording of contracts; but the pharmacist should be responsible for the ordering and also the storage. Where the pharmacist is employed only part-time, packages arriving while the pharmaceutical department is closed should be delivered to a designated person who would generally be the matron. (For arrangements in hospitals with no pharmaceutical departments see Section V.) The ordering of medicines and poisons for hospital laboratories or research departments can be undertaken either by the head of the department or by the pharmacist but should not be left to one of the junior laboratory staff.

19. Storage in the pharmaceutical department. We suggest that where bulk supplies of Dangerous Drugs are to be stored, a safe may be preferable to an ordinary cupboard and no one should have access to this but the pharmacist. If necessary a small known quantity of Dangerous Drugs can be kept in an ordinary locked cupboard for use by the medical staff in an emergency. Any special arrangements of this nature that may be made for giving a doctor access to Dangerous Drugs in emergency must be proof against abuse.

20. Supply to wards and departments. We discuss the mechanics of ordering by wards from the pharmaceutical department in the following Section. In our view, it would be a great help to all concerned if a uniform procedure were adopted and standard forms used. This is in line with our opinion that the complications of the custody of Dangerous Drugs and the routine associated with their custody for the nursing staff are sometimes unduly confusing.

21. Special arrangements should be made for the delivery of Dangerous Drugs to the wards. It is a matter for local arrangement whether they are collected by a member of the ward staff (although we deprecate the use of nursing staff as messengers) or handed over to a third party for delivery, but we take the view that whatever method is used, the pharmacist should obtain the signature of the recipient when they leave his hands. This is of particular importance when they are passed to a third party for transmission. It follows that only persons of the requisite degree of responsibility should be employed for the conveyance of Dangerous Drugs from one authorised possessor to another. This person may well be a porter or a van driver employed by the hospital or by an outside transport contractor, provided that he is aware of the responsibility which has been entrusted to him. This is, of course, to hand over the drugs to a person appointed to receive them, and not to allow them out of his possession until the carbon copy of the order (see Appendix I(a)) has been signed.

22. Disposal of unwanted drugs. Individual doses of Dangerous Drugs which are prepared and not used should be destroyed in the wards and recorded as such, but where a part of the contents of a container of drugs remains unused it should be returned to the pharmaceutical department. In addition arrangements should be made for part-used containers of Dangerous Drugs brought in by patients to be sent to the pharmaceutical department for disposal. It would in our view be wrong to return such drugs to the patient with his ordinary possessions on discharge: the hospital should not take the responsibility of handing over to the

patient Dangerous Drugs over and above any prescribed for him by the doctors who for the time being are in charge of his medical treatment. Small quantities of unwanted Dangerous Drugs from the wards should be destroyed in the pharmaceutical department in the presence of a witness and appropriate entries made in the Ward Dangerous Drugs Record Book.

23. When a larger quantity has to be destroyed the hospital pharmacist should apply to the Home Office enclosing a detailed list of the drugs to be destroyed. The Home Office will normally authorise destruction on condition that the destruction itself is witnessed by a responsible officer (who should not be a member of the pharmaceutical staff) designated by the hospital authorities for that purpose and that they are notified when destruction has been completed and appropriate entries have been made in the records. In hospitals which have no pharmacist, arrangements should be made for the unwanted drugs to be destroyed by a pharmacist in the hospital group.

24. We have twice been told in evidence of the finding of large quantities of old Dangerous Drugs, in one case dating from as far back as 1927, lying about in odd corners of small hospitals. It was suggested to us that there must be altogether a very large quantity of such drugs in hospitals throughout the country, remaining forgotten where they might be a temptation. More often, no doubt, people know they are there but leave them where they are because they do not know how to dispose of them.

III. Wards and Departments: prescribing, ordering, administration, and records

25. Prescribing. The Dangerous Drugs Regulations provide that prescriptions passed on to the pharmaceutical department must be written, but the Regulations do not contain anything to prohibit administration of the substance concerned to the patient on verbal directions if the sister happens to have the substance in her ward stocks.

26. We suggest that for the doctor to give a verbal order for drugs to the sister when he sees the patient is indefensible, and for the doctor to give a verbal order for drugs over the telephone, save in exceptional circumstances, is in our view unsatisfactory. Yet this has become almost a routine in some places, particularly in private wards where there are no junior medical staff to take the responsibility. In one Region every hospital has already agreed to put an end to this practice by making it a rule that drugs shall not be administered without a written prescription, except in a real emergency. We think this example should be followed everywhere and in any event if a drug is given by the nursing staff without written authority it should be immediately recorded on the treatment sheet by the nurse and certified by the doctor within 24 hours.

27. It was pointed out to us in evidence that there is a good deal of confusion about the exact meaning of the commonly used abbreviations, "P.R.N." (*pro re nata*) and "S.O.S." (*si opus sit.*) A number of doctors have been asked for an explanation of what they mean by writing "P.R.N." and "S.O.S." and nurses

have been asked what they have been taught to understand by such abbreviations. Their replies differ. Such wide variation of interpretation suggests that these abbreviations should not be used and in our opinion the directions should be written in English.

28. There is no legal objection to signing a prescription on a bed-card or case sheet with initials only, but this practice makes it almost impossible for the pharmaceutical department of a large hospital, where staff changes are frequent, to verify that prescriptions are genuine. We are in favour of the rule adopted by a London teaching hospital: a full signature is required the first time a particular doctor signs a particular treatment sheet, but initials are permitted for subsequent signatures on the same sheet.

29. Ordering and accounting for stock from the pharmaceutical department. The ward stock of drugs normally consists of drugs in bulk or in multi-dose containers which are kept in the ward cupboard in anticipation of future needs. Dangerous Drugs and poisons can in general be supplied to wards for ward stock on the written authority of the nurse in charge of the ward. In our opinion the ward sister should not have the authority to order an extra drug for inclusion in the ward stock until she has obtained the authority in writing from a member of the senior medical staff. In some hospitals a medical sub-committee has been formed for the purpose of agreeing, in consultation with the hospital pharmacist, a list of the substances which may be ordered for stock. The aim should be to cover routine needs and foreseeable emergencies, but not every conceivable emergency. When the list is agreed the existing stock should be adjusted to correspond.

30. The ordering of Dangerous Drugs and Schedule I poisons for stock is a responsible and important task and whenever possible it should be done by the sister herself. Should she be away for more than a short period it should be done by the acting sister.

31. We found considerable variation in practice in recording the use of drugs and were concerned at the complications caused for the nursing staff, particularly when they move from one hospital to another. Although under the Dangerous Drugs Regulations the ward sister, almost alone of the authorised possessors, is not obliged to keep a register of drugs obtained* and supplied, it is normal practice in most hospitals for a record to be kept of Dangerous Drugs administered. But it seems to be more the exception than the rule for any attempt to be made to balance the quantities used against the quantities obtained. Moreover in many hospitals the records once made are never scrutinised, so that if a sister is lax or particularly hard pressed the records may come to be kept very badly, or not kept at all. In other hospitals the matron makes it her business occasionally to ask to see the record, and in others again the pharmacist sees it from time to time. A few hospitals also keep a record of Schedule I poisons.

32. In our view a uniform system should be followed throughout the country for ordering Dangerous Drugs and for accounting for their use, and it should be one which involves a balancing of receipts against outgoings so that a loss is automatically brought to notice, and which lays the ward record open to regular scrutiny. We append model forms (see Appendix I) for this purpose which we suggest snould be printed centrally and used in every hospital for the ordering

* She must however keep for two years a copy of the orders she sends to the pharmaceutical department.

of ward stocks of Dangerous Drugs from the hospital pharmacy and for the recording of supplies and their administration in the ward. The forms for ordering Dangerous Drugs would be printed in duplicate and bound in book form. One copy of the order form would be retained in the pharmaceutical department. The order book would normally be kept in the ward. The forms recording their use would also be bound in book form, a separate record form being used for each drug and for different strengths of the same drug. We recommend the keeping of two "stock bottles", or whatever the container may be, for commonly used substances so that one can be sent down and renewed at leisure, and where applicable returned to the ward before the one in use is finished. This not only allows the completing of the account to the last dose before each container is returned but also removes all temptation to transfer that last dose to some inappropriate and unlabelled container while the proper container is sent down for renewal.

33. Care should be taken that if on any occasion Dangerous Drugs are taken from stock for some purpose other than administration to patients, for example to lend to another ward, or if a dose of a drug is made up and for some reason not used, an appropriate entry is made in the Ward Dangerous Drugs Record Book. It is clearly desirable that borrowing between wards should be kept to a minimum.

34. While we think it important that there should be a uniform procedure for the requisitioning from the pharmaceutical department of preparations other than Dangerous Drugs, we are not recommending a standard book. Requisitions should be written in duplicate order books and signed by the authorised person, the book being sent down to the pharmaceutical department with the empty container. It should be emphasised that it is particularly important that orders for stock preparations that are poisons or contain poison should state the strength where appropriate, and quantity required.

35. It is realised that where injections are made up in multi-dose containers the two sides of the ward's drug account will not balance exactly: it is not possible to obtain thirty separate doses from a thirty-dose bottle. In fact for the reasons stated in the next Section (paragraph 56) we hope that the use of multi-dose containers will be kept to a minimum.

36. Samples of drugs received by hospital doctors are sometimes to be found in the hospital ward. Apart from the risk of misuse, their retention in the ward as part of the ward stock of drugs prevents the proper accounting for stocks. All such samples found in the ward should be sent to the pharmaceutical department of the hospital.

37. We understand that house officers and other doctors sometimes ask the nurse in charge of the ward to let them have the key of the ward drug cupboard, for the purpose of getting a drug for a patient. This practice may lead to abuse. The custody of the drugs in the ward Dangerous Drugs and Schedule I poison cupboards is the responsibility of the ward sister, or her official deputy, and no persons should have access to the cupboards or permission to take drugs from them except in the presence of the nurse officially holding the keys.

38. Administration of medicines by the nursing staff. It is obviously desirable that the administration of medicines should be under strict control. In some hospitals qualified nurses only are allowed to undertake this duty; in others nurses in

training administer medicines as an essential part of their training. We recommend, however, that this duty must remain the responsibility of the sister or acting sister for the time being in charge of the ward, who should exercise such control as may be necessary when her nurses are required to perform this duty.

39. We also recommend that every medicine, whether or not it be a Dangerous Drug or Schedule I poison, should be checked against the prescription (i.e. the treatment sheet) at the bedside immediately before administration. In Appendix II we describe a method by which this could be carried out. We realise that this method entails the administration and checking of drugs by two persons. We recommend that this should be the practice, particularly with Dangerous Drugs, Schedule I poisons and any other substance for which a calculation or intricate preparation is required before it may be administered, though it is recognised that this may not always be possible.

40. In recommending that the prescription should be the focus of the checking system, we are aware that it is now a common practice for a "medicine list" to be used for checking purposes. We would condemn this use of the "medicine list" as there is always the risk that the drug has been changed or stopped on the treatment sheet since the "medicine list" was prepared. The "medicine list" may have a use as a drug time-table in assisting a nurse to select the drugs required for a medicine round, but this should be its only use. In any case, it should not give details of dosage, so that the nurse is forced to refer to the prescription before a dose is given.

41. There is a special problem in dealing with the administration of drugs at night. It is not uncommon for the senior nurse on night duty in a ward to be a nurse who has not yet qualified. In these circumstances we recommend that *all* drugs should be administered and checked by two persons. The night sister will be called when there is any unusual or unfamiliar detail, or when for any reason the nurse is in doubt. The night sister would then carry out the procedure set out in Appendix II.

42. We would particularly condemn the practice, most commonly adopted at night, of putting out drugs in advance so that the dosage can be checked by someone who never sees the drug administered. In our view it is preferable to have a less qualified, or unqualified, witness who can actually be present at each stage of the preparation and administration of the drug.

43. There is one further point to which we should like to call attention. Nurses commonly administer mild analgesics and aperients without the authority of a doctor. We consider that in general no medicines should be given by a nurse unless ordered. If, however, authority to give certain medicines is given to qualified nursing staff to give such medicines on their own responsibility, this authority should be recorded by the doctor on the patient's treatment sheet and the administration recorded by the nurse for the doctor to see. These records are important; even such drugs as aspirin may be inadvisable. There are some hospitals, especially maternity hospitals, where permission to give certain drugs could be authorised in general terms and the administration of such drugs would of course be recorded in detail on the patient's treatment sheet. In the case of Dangerous Drugs administration without prior authority is actually illegal: and it should be noted that this includes the administration of pethidine by hospital midwives, who, unless they carry out the whole procedure of

"Midwife's Supply Order" and "Drugs Book" laid down for midwives who notify their intention to practise, are in a position no different from that of any of the hospital nursing staff in relation to Dangerous Drugs. (See Section VI.)

44. We consider that it should be a rule that medical authority must be sought before anything not included on the patient's treatment sheet is administered by the sister or nurse in charge. In this connection we would draw attention to the need for all current medicines for a patient to be re-written on the top sheet where more than one sheet is used thus cancelling prescriptions on previous sheets. We were told of an instance in which there were as many as 27 separate treatment sheets for one patient.

45. Various arrangements have been made in hospitals regarding stocks for night use. Sometimes there are special poisons cupboards in the corridors, of which the night sister has the key; sometimes there is a single cupboard in her office; or occasionally she has a special portable container for drugs. More frequently the same cupboards are used both by day and by night, the ward sister handing over the key when she goes off duty to the night nurse or night sister. It should be noted that in the case of Dangerous Drugs it is only the "sister or acting sister in charge of the ward" who is authorised to be in possession, but this description could probably be applied with equal justice either to the night sister who has general charge of all wards, or to the nurse in charge of the actual ward. In small hospitals where the matron is in fact acting as night sister it would apply to her. We recommend the use of the same cupboards both by day and by night. This obviates in the first place the problem of what to do with the key of the day cupboard by night and the key of the night cupboard by day, and secondly ensures that there is no discrepancy between the administration of Dangerous Drugs to the ward's patients and the issue of Dangerous Drugs from the ward's stocks: it clearly complicates the checking of records if the administration of the same drug to the same patient is recorded sometimes against the ward's own stock and sometimes against a quite separate stock in the night sister's cupboard.

IV. Wards and Departments: storage, containers, and labelling

46. Storage. We have devoted some time to this matter, which is one of those on which there is at present great diversity of practice. The statutory requirements are only two: that Dangerous Drugs should be stored so that they are accessible only to the authorised possessors—the ward sisters or acting sisters; and that Schedule I poisons should be stored in a cupboard or shelf reserved for poisons and "other dangerous substances".

47. We heard evidence from several sources that not only Dangerous Drugs and poisons but all medicines should be kept under lock and key. With this on consideration we agreed. There are many medicines outside the Poisons List which could harm or kill patients if taken in the wrong circumstances, and they should be treated with due respect. However, we decided against the suggestion made by one body that in storing drugs no distinction at all should be made

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52. We have seen draft specifications prepared by the British Standards Institution for a standard poisons cupboard, with an inner locked compartment for Dangerous Drugs. This cupboard seems to us well adapted to its purpose.

53. **Custody of Drugs.** Arrangements should be made for the storage of patients' valuables and other articles needing to be kept under lock and key which do not involve placing them in the drug cupboard even as a temporary measure in emergency.

54. We would also draw attention to the fact that no department should have a Dangerous Drugs cupboard unless there is an authorised possessor, who would normally be a nurse, personally responsible for the Dangerous Drugs in the cupboard. We have in mind especially radiological and psychiatric Departments.

55. **Limitation of ward stocks.** We believe that there is a tendency among ward sisters to accumulate too wide a range of drugs and medicines. The result is that cupboards are overcrowded with bottles the purpose of which is forgotten, that drugs may be used which are inert and that losses may pass for a very long time unnoticed. The intention no doubt is to be prepared for any eventuality, but this is in our view misguided: the advantages gained are not worth the dangers. We have been told of serious results in two successive cases in the same hospital where ward sisters produced from their stock in emergency a drug which should only be dispensed for immediate use because of its short active life and proved in fact in both cases to have deteriorated. Also, certain drugs such as paraldehyde become dangerous. Supplies again get inflated because some house officers as they come and go tend to order a drug of their own particular choice, then they move on, and the drug remains unused on the shelf. (See paragraph 29).

56. **The "stock bottle" and multi-dose container.** The misuse of injectable Dangerous Drugs is rendered very much more difficult when the drugs are dispensed in single-dose containers. We should have liked to recommend that multi-dose containers for Dangerous Drugs should be banned altogether, save for a few exceptional cases, but we decided in the end that it would be difficult for the Minister to insist on this, since the change might involve an appreciable increase in the time, trouble and expense of making up drugs in certain hospitals where a single "stock bottle" had to be replaced by a considerable number of ampoules with various strengths and combinations of the drug. We believe, however, that if the medical staff will co-operate the extra work involved need not be large: we were told of one hospital with a very big consumption of morphine where since the "stock bottle" has been abolished nothing but $\frac{1}{6}$-grain and $\frac{1}{4}$-grain ampoules have been supplied for stock, without apparently causing any difficulty. We know of many hospitals of all types where single-dose containers have long been the rule and we hope that other hospitals will before long follow their example.

57. We consider it important that the different types of medicaments and their various methods of administration should be distinguished by means of containers and labels. We accordingly make the following recommendations and to ensure uniformity we think that they should be adopted by all hospitals.

58. Liquids. Liquid preparations used in hospitals may be divided into the following categories:

(i) Liquids for oral or parenteral administration.

(ii) Liquid medicines for all other treatment (e.g., eye drops, nasal drops, liniments, inhalations, bladder wash-outs, mouth washes, lotions, liquid antiseptics).

(iii) Liquids other than medicines (e.g., laboratory reagents, general disinfectants).

59. Where liquids for other than oral or parenteral administration are statutory poisons and are supplied to a hospital in bottles holding not more than 120 fluid ounces, Rule 23 (1) of the Poisons Rules requires the outer surface of the bottles to be fluted vertically with ribs or grooves recognisable by touch. The Rules have recently been amended to extend this requirement to bottles made of materials other than glass. The Rules do not, however, include any requirements on the type of container to be used for liquids supplied from a hospital to outpatients or issued for use within a hospital. Hospital pharmacists have had to make their own arrangements and to ensure uniformity we make the following recommendations:

A distinction should be made between bottles containing liquids for oral and parenteral administration and those containing all other liquids (e.g., turpentine, liquid detergents, camphorated oil and industrial methylated spirit). We think that the use of coloured bottles is unsuitable as a cautionary device because many liquids must be stored in such bottles to protect them from light, irrespective of whether these liquids are for oral or parenteral administration, or for external use. Distinctively shaped bottles were also considered and thought to be unsuitable. **We realised that the wider use of fluted bottles might detract from their cautionary value, but we agreed, on balance, that in addition to their use for statutory poisons, the use of fluted bottles would be justified for all other liquid preparations which are not intended for oral or parenteral administration.**

60. We therefore recommend that bottles containing liquid preparations not intended for oral or parenteral administration (that is, all those mentioned in the foregoing categories (ii) and (iii)) which are issued to outpatients or for use within a hospital should be fluted vertically with ribs or grooves recognisable by touch.

61. Tablets. These may be divided into the following categories:

(i) Oral tablets.

(ii) Tablets intended for the preparation of hypodermic injections (where these are still used).

(iii) Implants intended for insertion beneath the skin.

(iv) Other non-oral tablets.

62. Since we think that all tablets are often believed to be for oral administration, we recommend that bottles containing tablets other than those intended to be taken orally or to be used for the preparation of hypodermic injections or for implantation, should also be fluted vertically with ribs or grooves recognisable by touch. These recommendations for tablets follow the same pattern as those recommended for liquid preparations.

63. Solids. Solids are mainly used in hospitals as ingredients of other preparations and are less frequently dispensed as such. Furthermore, their uses are so varied that we feel we could not make precise recommendations on containers. (An example is Epsom salts, used either in baths or as a laxative.) Where a solid preparation is dispensed as such the pharmacist will select the type of container he considers most suitable for it. We recommend that the preparation should be labelled in accordance with the general rules set out below.

64. Suitability of containers. The type of container selected for any substance or preparation should ensure maintenance of the potency of the contents for as long as possible, if the prescribed storage conditions are observed. We recommend that tablets should wherever possible be dispensed in glass bottles or vials or in similar permanent containers, and the use of cardboard boxes, chip boxes and envelopes should be discontinued.

65. Most nurses know in theory that they should never transfer a drug from the original to another container. It is frequently done and is the cause of accidents.

LABELS

66. The importance of the label. We wish to emphasise that the label is an essential link between the prescriber and the patient. It should be read most carefully and should never be defaced or altered. If a label becomes damaged by accident, the container should be returned immediately to the pharmaceutical department and not be relabelled by the nurse.

67. The manner of labelling containers. We recommend that the label should be placed on the body of a container and never on the lid.

Our detailed recommendations are as follows:

68. All preparations supplied from a pharmaceutical department. We recommend that all preparations supplied from a pharmaceutical department to the wards and departments of a hospital should be labelled with the following details, in addition to those, recommended later in this report, for poisons and Dangerous Drugs. (Except where indicated, these recommendations apply both to preparations issued for stock and to those prescribed for individual patients.)

(*a*) An accurate description of the contents, that is to say, the name of the preparation and, where appropriate, the strength. Names of substances should, wherever possible, be Pharmacopœial or other approved names. Other names should be smaller in size and character. Local names such as "Mixture X" should not be used without a statement of composition, except in certain instances where preparations are being used for clinical trial.

(*b*) The patient's name, on preparations prescribed for individual patients.

(*c*) Directions for use, on preparations prescribed for individual patients. Because directions for use, including dosage, may vary from patient to patient these details would not normally appear on the labels of stock preparations.

(*d*) The name or number of the ward.

(*e*) An expiry date, where appropriate (in conjunction with specified storage conditions). Preparations which do not bear an expiry date should be labelled with a code or batch number to indicate the date of issue or preparation. (See also paragraph 72 below.)

(*f*) Storage conditions, if any.
(*g*) The word "Reagent", for all preparations of this type.
(*h*) A special warning, at the pharmacist's discretion, for particular substances; e.g., the words "Highly Inflammable" where appropriate.

69. Poisons and preparations containing poisons, including Dangerous Drugs and Schedule I poisons. These should bear the following additional particulars:
(*a*) The word "Poison" on all preparations supplied for stock but not for individual prescriptions.

Our reason for recommending the labelling of all such preparations with the word "Poison" as an extra precaution is that, unlike preparations prescribed for individual patients, they do not bear directions which the pharmacist has checked for unusual features and, if necessary, confirmed with the prescriber.
Whether for individual patients or stock:
(*b*) The words "For external use only", for an embrocation, lotion, liquid antiseptic or other liquid medicine for external application. (These words should not be used for preparations intended for use on mucous surfaces. Like every other preparation these medicines will be specifically labelled and they will also be distinguished by being in a fluted bottle.)
(*c*) The words "Not to be taken", for a preparation not to be used medicinally (e.g. a laboratory reagent or a general disinfectant).

Schedule I poisons other than Dangerous Drugs. These should bear the following additional wording: "Store in Schedule I poison cupboard".
Dangerous Drugs. These should bear the following further additional wording: "Store in Dangerous Drug cupboard".

70. Dangerous Drugs and Schedule I poisons supplied direct from a wholesaler or manufacturer to a hospital without a pharmaceutical department. Dangerous Drugs are generally labelled as such by the manufacturers and when received in a hospital without a pharmaceutical department should be stored in the locked Dangerous Drugs cupboard. Manufacturers or wholesalers must label Schedule I poisons with the word "Poison", or other prescribed indication of character, in red or set against a red background (Poisons Rule 20 (2)). We therefore recommend that the person responsible for receiving drugs in a hospital without a pharmaceutical department should store in the locked Schedule I cupboard all substances labelled in this way. (It would assist hospitals if manufacturers would mark Schedule I poisons as such and not merely with the word "Poison". This would distinguish Schedule I poisons from other poisons.)

71. New experimental drugs. In view of the fact that certain new drugs have not been classified as poisons or Dangerous Drugs until they have been in circulation for some time, we consider that the pharmacist or the consultant should have discretion to decide whether any of these drugs should be treated as Schedule I poisons within his hospital.

72. The dating of preparations supplied for use within a hospital. We wish to draw the attention of pharmacists to the desirability of indicating in code or by means of batch numbers the date of manufacture or issue of stock preparations which may be stored in wards for indefinite periods. The stability of such preparations need not concern the nursing staff, but a code or batch number would provide the pharmacist with a guide to the necessity for withdrawal or replacement of stock preparations which he believes may have deteriorated.

Preparations having a definite expiry date and precise storage conditions necessary to maintain potency to this date must be labelled clearly with these details, for observance by the nursing staff.

PREPARATIONS ISSUED TO OUT-PATIENTS

73. We recommend that these should bear the following particulars:

All preparations

(*a*) The type of preparation (e.g. "The Mixture", "The Tablets") and any prescribed direction for use.

(*b*) A designation and address sufficient to identify the hospital from which the preparation was supplied.

(*c*) Where appropriate, an indication of potential danger. (Such as a warning to keep out of the reach of children as recommended in paragraph 74 below.)

Poisons. These should bear the following additional wording:

(*a*) The words "For external use only", for an embrocation, lotion liquid antiseptic or other liquid medicine for external application, made up ready for treatment—(Poisons Rules 21 (1)). (These words should not be used for preparations intended for use on mucous surfaces.)

(*b*) The words "Not to be taken", for a liquid not to be used medicinally (Poisons Rules 21 (1)).

Note. These substances will also be distinguished by being in a fluted bottle.

74. As indicated in the foregoing paragraph, medicines for out-patients will not be labelled "Poison" if they are made up ready for treatment (though they must be labelled "For external use only" when appropriate). We would stress the need for ensuring that *all drugs* issued for use at home, whether poisons or not and especially those likely to be attractive to small children, should not be accessible to a child. Patients should be warned of the danger and in the case of highly coloured tablets and capsules, which are particularly attractive, the warning should be reinforced with a cautionary label "To be kept out of reach of children". A printed card drawing attention to the danger should also be displayed prominently in the out-patient department.

75. In the letter which should immediately go to the general practitioner when the patient leaves hospital, the supply of drugs given to the patient to take away should be recorded, otherwise there is a risk that the patient might continue taking drugs received from the hospital as well as those prescribed by the general practitioner. In some out-patient departments Dangerous Drugs and poisons, such as barbiturates, are dispensed in large quantities at a time. The motive is, no doubt, to save the patient an unnecessary journey to hospital. We consider this practice to be dangerous and if the co-operation of the family doctor is sought it should rarely be necessary.

76. The labelling of ampoules presents special problems on which advice has already been given by the Standing Medical Advisory Committee's Sub-Committee on the Injection of Wrong Solutions.

V. Hospitals without a pharmaceutical department

77. Hospitals without a pharmaceutical department have special problems to face. We are not suggesting that the control of drugs in them is necessarily less efficient than in a larger hospital: in fact we gathered in evidence that where the matron of the hospital takes her special responsibilities seriously the danger of abuse may be if anything less in a small than in a big hospital, because the intimate contact among the small staff makes deception particularly difficult. We also learnt from the evidence submitted to us concerning past cases of addiction that these addictions are as likely to be contracted in large hospitals as in small ones, though there is some evidence that once a hospital employee becomes an addict he tends to gravitate towards a smaller hospital, if only because he is less likely to meet someone acquainted with his past. Nevertheless it is true that there are certain extra difficulties in establishing an efficient system of drug control in the small hospital.

78. The first point of difficulty is the obtaining of supplies. This is sometimes done through a retail pharmacist and sometimes through the pharmaceutical department of a neighbouring larger hospital, the chief pharmacist of which serves both hospitals. In general we think the latter type of arrangement better, because the drugs can be made up, labelled and records kept, in the same manner as in other hospitals, and because the standard of care at the smaller unit is likely to benefit from the contact with the hospital pharmacist, but we recognise that it will not always be practicable.

79. Orders for Dangerous Drugs require counter-signature by a doctor. This is an awkward requirement where doctors do not attend the hospital regularly, and it may also appear a barren one since a signature is often obtained from the first available doctor who has not the knowledge to check whether the order is reasonable, but it is a requirement of the Dangerous Drugs Regulations and we are not disposed to recommend that it should be altered. It may seem at first sight anomalous that a ward sister can obtain drugs on her own authority (i.e., from the hospital pharmacist for her own ward stock) but not a matron. It must be remembered however that the matron in ordering bulk supplies for general stock from outside sources for re-issue to the ward is assuming the functions of a pharmacist. Moreover the matron cannot always be directly responsible for the administration of the drugs.

80. Special arrangements will have to be made for the delivery of Dangerous Drugs to the hospital. They should be delivered into the hands of the matron or her deputy who should sign a receipt and at once put away the drugs in the Dangerous Drugs cupboard from which ward stock will be issued.

81. The ward sister will obtain Dangerous Drugs and poisons, with other medicines, from the matron. Each ward sister should have her own supply for her ward stock for the use of which she is wholly accountable. The appropriate forms should be used and the matron should check that the records of administration of the previous order have been completed.

82. In obtaining her supplies of Dangerous Drugs from another hospital, we suggest that for convenience the matron might also use the standard forms used by ward sisters (see Appendix I). A Dangerous Drugs register would, however,

also have to be kept. Where the circumstances are appropriate the wards in the small hospital can be treated as if they were wards of the parent hospital and receive supplies on direct requisition from the ward sister.

83. The keys of the matron's Dangerous Drugs and Schedule I poisons cupboards should be kept on the person of the matron or her deputy, in the same way as the ward sister keeps the keys of her cupboards.

VI. Midwives in Hospital

84. It is well known that midwives are in a special position under the Dangerous Drugs Act. The Act lays down a procedure by which domiciliary midwives obtain and administer certain Dangerous Drugs on their own authority. We have considered whether there are any circumstances in which midwives who have notified their intention to practise in hospital should follow the same procedure, as they have power to do under the Act. So far as we can see, however, it is preferable, even in the smallest general practitioner maternity units without resident medical staff, for midwives to use the normal hospital procedure rather than the procedure followed in domiciliary work.

85. The main point that we wish to make in this connection is that unless the midwife does follow the whole procedure which domiciliary midwives follow (which includes the authorising of supplies by the Medical Officer of Health or his authorised deputy and the maintenance by each midwife of her own "drugs book" recording each administration) she has no more rights in relation to Dangerous Drugs than an ordinary nurse. She can neither possess nor administer Dangerous Drugs without authority. The common impression that any practising midwife has the right to the key of the ward drugs cupboard is erroneous: the same formalities should be observed in labour wards as elsewhere.

VII. Suspected offences

86. All the evidence we have shows that the incidence of cases of abuse of Dangerous Drugs in National Health Service Hospitals is extremely low. Nevertheless cases do arise and we are not altogether satisfied that they are always handled wisely. Sometimes the main desire of the hospital authority or the senior hospital staff appears to have been to avoid unpleasantness. Those concerned are informed that something seems amiss and an informal inquiry is begun, in the utmost secrecy: one or more members of the staff immediately tender their resignations on "personal grounds," and the matter is dropped forthwith. This procedure is not in the interest of either the Service or the addict. The addict probably immediately obtains a similar post in another hospital where he or she may continue to have access to Dangerous Drugs to his or her greater harm and to the danger of patients. It is of the utmost importance that any person who has this weakness should receive treatment at the earliest possible stage and it is with this in mind that we have no hesitation in urging hospital authorities to consult the police wherever they have grounds for

suspecting that one of their staff is misusing or misappropriating Dangerous Drugs. We are informed that the police themselves in such cases are chiefly concerned that the offender should be put on the right lines for treatment rather than be punished by prosecution. And for this reason we believe that no attempt should be made by the Board of Governors or the Management Committee to hold an inquiry of their own before calling in the police.

87. Anyone discovering an apparent loss of Dangerous Drugs should report the matter to his or her senior officer. In any case of apparent loss where the hospital has its own pharmacist, he should be consulted in order to see whether he can confirm the suspicion of loss. If there seems to be no satisfactory explanation the loss should be recorded in the appropriate record book and the matter should be reported immediately to the Senior Administrative Officer whether House Governor, Medical Superintendent or Group Secretary. If the matron and the Chairman of medical staff are not already aware of the circumstances they should be informed and consulted and the matter should be reported immediately to the Chairman of the Board of Governors or Management Committee. We recommend that it should be only the loss of such drugs, and not the name of any person who is thought to be concerned, which is reported to the police who are accustomed after inquiry to decide if and when there is sufficient evidence to suspect any one individual.

88. We are also concerned to find how often an addict finds his way back into the hospital service even when proceedings have been initiated against him. Often he avoids for a time both police proceedings and disciplinary action by the professional body concerned by retiring into a mental hospital as a voluntary patient. On other occasions the case may be dismissed or the offender put on probation on condition that he goes into hospital for treatment. Later he discharges himself—there are no powers under which addicts may be detained in hospital—and applies successfully for another post in hospital. He or she may use forged references or a false name, or the addict may rely on slackness on the part of employing authorities in checking prospective employee's credentials. Gaps in employment may for instance be accounted for in the case of nurses by references to the nursing of sick relatives.

89. We have been unable to see any way in which these difficulties can be avoided entirely, but if there is no satisfactory explanation of protracted absence from duty we do urge hospital authorities at least to write to the last employer and to the professional body concerned.

90. Authorities should remember that where a midwife is concerned in an offence it should be reported to the local Supervising Authority.

91. There is one more general point we should like to make. In our view both doctors and nurses are told too little when training about their statutory obligations in relation to Dangerous Drugs and poisons. In our view medical schools and nurse training schools should see that this deficiency in training is made good. We agree with the Linstead Committee that the pharmacist is not necessarily the best person to teach nurses *materia medica*, but we think it is very desirable that the forensic aspects of this subject should be handled by the pharmacist: he will be able to show them how their functions under the regulations relate to his, and also to encourage them to turn to the pharmacist for

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12. Additions to the range of stock drugs held in the ward should not be made without senior medical authority. (Para. 29.)

13. A uniform system should be followed for ordering Dangerous Drugs and for accounting for their use. (Para. 32 and Appendix I).

14. The use of multi-dose containers should be kept to the minimum. (Para. 35.)

15. Doctors' samples of drugs found in the wards should be sent to the pharmaceutical department. (Para. 36.)

16. The keys of the ward Dangerous Drugs and Schedule I poisons cupboards should always be in the possession of the nurse in charge of the ward. (Para. 37.)

17. A standard method for checking drugs administered by the nursing staff should be adopted. (Paras. 38–41 and Appendix II.)

18. Drugs should never be put out in advance and the administration should always be checked and witnessed. (Para. 42.)

19. Normally only prescribed medicines should be given by a nurse. (Para. 43.)

20. Medical authority must be sought before anything not included on the patient's treatment sheet is given to the patient by the nursing staff. (Para. 44.)

21. The same drug cupboards should be used both by day and by night. (Para. 45.)

22. Each ward unit should have a separate cupboard for each of the following: Dangerous Drugs; Schedule I poisons; other medicines; reagents; and for disinfectants and cleaning materials. (Para. 47.)

23. The Schedule I poisons cupboard should contain only (a) Schedule I poisons and (b) other substances marked by the pharmacist "Store in Schedule I poisons cupboard". (Para. 48.)

24. Drugs intended for internal use should be stored on separate shelves from those intended for external use. (Para. 50.)

25. Drug cupboards should not normally be in a separate room. (Para. 51.)

26. Ward stocks should be limited to the range of drugs and medicines normally required. (Para. 55.)

27. Bottles containing liquid preparations not intended for oral or parenteral administration should be fluted vertically with ribs or grooves recognisable by touch. (Para. 60.)

28. Bottles containing tablets not intended for oral or parenteral administration should be fluted vertically with ribs or grooves recognisable by touch. (Para. 62.)

29. Tablets should, wherever possible, be dispensed in glass bottles, vials, or similar permanent containers. (Para. 64.)

30. Containers requiring fresh labels should be returned immediately to the pharmaceutical department. (Para. 66.)

31. The label should be placed on the body of the container and not on the lid. (Para. 67.)

32. Standard wording should be used for the labelling of preparations. (Paras. 68–74.)

33. The hospital pharmacist or consultant should have discretion to decide whether a new experimental drug should be treated as a Schedule I poison. (Para. 71.)

34. Large quantities of drugs should not be dispensed to out-patients. (Para. 75.)

35. Midwives working in hospitals should follow the normal hospital procedure in regard to Dangerous Drugs rather than the domiciliary procedure. (Paras. 84–85.)

36. A procedure for use in hospitals for dealing with the loss of drugs liable to lead to addiction. (Paras. 86–87.)

37. Medical and nurse training schools should arrange for more detailed training in the statutory obligations in relation to Dangerous Drugs and poisons. (Para. 91.)

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5th December, 1956

Appendix I (a)

(See paragraph 32)

WARD DANGEROUS DRUGS ORDER BOOK

(Model Sheet and carbon copy)

Serial No.....

.....Hospital

Order for Dangerous Drugs

Ward or Department.....

Name of Preparation	Strength	Quantity

(Each preparation to be ordered on a separate page)

Ordered by ..... Date.....
(Signature of Sister or Acting Sister)

Supplied by ..... Date.....
(Pharmacist's signature)

Accepted for delivery .....
(Signature of Messenger)

Received by .....
(To be signed in the ward in the presence of the messenger)

TO BE RETAINED IN THE PHARMACEUTICAL DEPARTMENT

Serial No.....
(Carbon copy)

.....Hospital

Order for Dangerous Drugs

Ward or Department.....

Name of Preparation	Strength	Quantity

(Each Preparation to be ordered on a separate page)

Ordered by ..... Date.....
(Signature of Sister or Acting Sister)

Supplied by ..... Date.....
(Pharmacist's signature)

Accepted for delivery .....
(Signature of Messenger)

Received by .....
(To be signed in the ward in the presence of the messenger)

TO BE RETAINED BY THE SISTER

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Appendix II

(See paragraph 39)

A METHOD FOR CHECKING DRUGS ADMINISTERED BY THE NURSING STAFF

1. Read the prescription carefully.
2. Ascertain that the prescribed dose has not already been administered.
3. Select the drug required and check the label with the prescription.
4. Prepare the drug in the presence of a witness who should check with the prescription, (*a*) the drug, (*b*) the calculation if any, (*c*) the measured dose and (*d*) the name of the patient.
5. Take the measured dose and the prescription to the bedside, check the identity of the patient and administer the drug in the presence of the witness.
6. Enter the details of the administration in the appropriate ward record book, which should never be a loose leaf book. In the case of Dangerous Drugs the details should be entered in the Ward Dangerous Drugs Record Book. Both these records should be signed in full by both donor and witness.

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Part II. On the State of the Public Health, being the Annual Report of the Chief Medical Officer (Cmnd. 325). 9*s.* (9*s.* 8*d.*)

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