Walsall Council

Walsall Children's Services
Better Together for Children

Administration and Storage of Medication

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Appendix 1 - Controlled Drugs List

Form A 'Medication Advice Record' Part 1 in the documents library

Form A, 'Medication Advice Record' Part 2 in the documents library

Form B Prescribed Medication Admission / Discharge Record in the documents library

Form C Prescribed Medication Administration Record in the documents library

Form D Non-Prescribed Medication Admission & Discharge Record in the documents library

Form E Non-Prescribed Medication Administration Record in the documents library

Form F Consent Form in the documents library

Form G Record of Medication Errors or Near Misses

Form H Medication Error / Near Miss Incident Log

1. Health Care Planning

1.1 It is vital that prior to admission, or in the case of an emergency admission then as soon as possible thereafter and no later than the 72 hour post placement meeting, that detailed health care planning is undertaken for the child. Health Care planning must involve the child, relevant health and social care professionals, including the named nurse for Looked After Children, and/or the Community Children's Nurse, and the parents / guardian, as appropriate to the child's circumstances.

1.2 Health care planning should be considered as part of the residential placement planning process and review. Where a child's health needs are more complex, a specific multi-agency meeting may be required.

1.3 Healthcare planning must include:

1. Details of GP and any other health care professionals involved in the child's care i.e. paediatrician, occupational therapist, physiotherapist, community nurse
2. Details of health conditions
3. Any special requirements
4. Medication and recording procedures; including consent for staff to obtain advice from a health professional for non prescribed medication in an emergency
5. Emergency procedures
6. Role of health / school colleagues

1.4 Prior to admission, or as soon thereafter, **Form A 'Medication Advice Record' Part 1** and **Form A, 'Medication Advice Record' Part 2** must be completed in conjunction with parents/carers and/or the child's Social Worker or relevant health professionals and a parent / health professional signature gained.

1.5 In the case of respite care **Form A 'Medication Advice Record'** must be reviewed at each admission to ensure the information is current. Where children are looked after on a full

time basis Form A must be reviewed at least 6 monthly or as medication circumstances change.

2. Medication Records

2.1 It is essential when a child is admitted to a residential placement that the residential staff on duty clearly record any prescribed medication the child brings with them. Any non-prescribed medication brought in on admission cannot be administered without health advice and should be stored and returned when the child returns home. If a return home is not likely, the medication should be returned to a pharmacy, or returned to the parent / guardian who purchased the item where applicable.

2.2 All prescribed medication received must be recorded on **Form B 'Prescribed Medication Admission / Discharge Record'**. Every child will have an individual Prescribed Medication Admission / Discharge Record. All prescribed medication must be recorded on this record. **Form C 'Prescribed Medication Administration Record'** must then be completed, documenting each medication to be administered. The name of medication / route, dose and time of administration must be clearly recorded.

3. Non Prescribed Medication

3.1 Anyone can buy a 'homely remedy', for example, paracetamol for a headache; it is the type of treatment that is required as soon as possible after the onset of symptoms.

3.2 A GP may prescribe something to take 'when required' when it is possible to predict in advance what that person may need, but the GP may not be willing to provide a supply of paracetamol for every one of their patients resident in a residential establishment just in case they may need it for an occasional headache or toothache.

3.3 As such the children's home will need to consider carefully whether or not to treat minor ailments with 'homely remedies'.

3.4 Where treatment for minor ailments are not prescribed for children, but residential staff recognise that a child may require treatment, they must:

- Refer to this policy on non-prescribed medication
- Consult or seek advice from a health professional i.e. pharmacist, nurse, GP/Paediatrician, or in extreme circumstances A&E
- Keep records of the purchase, administration and disposal of all homely remedies
- Make sure that the children's carers, relatives, GPs, paediatricians and school staff have read and understood the relevant sections of this policy

3.5 There are risks that prescribed medicines will interact with medicines and other products purchased over the counter and cause harm. These include:

- Herbal products
- Traditional Chinese medicines
- Health foods

Such products should not be administered without health advice / prescription.

3.6 Non prescribed medications should not be used without obtaining advice from a pharmacist, nurse or doctor. Health advice must be sought for individual children to avoid any risk of adverse reactions. As such it is not permissible to purchase homely remedies off the shelf (i.e. supermarket, local shop) without having obtained advice. Parents should be kept informed as appropriate see 3.8.

3.7 When consulting health professionals for advice staff should inform them of the child's prescribed medication listed on the **Medication Advice Record Form (Form A)** and any known existing medical condition to enable considered decision making about appropriate treatment for the individual child. In the event that a homely remedy is recommended, administered and symptoms persist, following a period not exceeding 24 hours, the child must be seen by a GP or Consultant. Any deteriorating condition should be referred to a doctor or consultant.

3.8 On no account should home/common remedies be administered to children without having obtained written consent of the parent or guardian. Consent for the administration of home/common remedies must be sought prior to placement or as soon as possible thereafter. See **Consent Form (Form F)**.

Any non-prescribed medication received at a Children's Home without health advice or receipt of a completed consent form cannot be administered.

Again do not give Home/Common remedies until you have consulted or sought advice from a Health Professional.

3.9 An account of this process should be recorded in detail on the child's Daily Record Sheet along with any conversations, outcomes or verbal instructions offered regarding the administration of the medication.

3.10 Children's Homes must not keep a general supply of home/common remedies for use by all children. All home/common remedies should be purchased, labelled (stating child's name, DOB and date of purchase) and administered for individual children.

3.11 Any home/common remedies administered by staff to children within the home should be clearly recorded on the **'Non-Prescribed Medication Admission & Discharge Record'**

(Form D) and the **'Non-Prescribed Medication Administration Record' (Form E)**.

4. Receipt of Medication and Setting Up Records

4.1 Two trained members of staff are required throughout the process of receiving medication and setting up records.

4.2 When a child admitted to a Children's Home has on-going medication, or when a prescription medication is obtained following a visit to a GP, the following procedure should take place:

4.3 Two members of staff should check that the labels on the containers/bottles clearly state:

i. The child's name

ii. Name of medication and route of administration

N.B. The route of administration is unlikely to be printed on the label, the child's care plan must be checked prior to administration of medication

iii. Dosage to be administered – if the dose is variable – full instructions should be included

iv. Frequency / times of administration if the dose frequency is variable – full instructions should be included

v. Expiry date of medication (if given)

vi. The contact details for the pharmacy, the date of dispensing and any relevant additional instructions for the medicine e.g. take with or after food

4.4 Any discrepancies **must** be reported to a manager immediately. In the case of out of hours, this would be the on call manager. In the event of discrepancies care staff must make every effort to clarify the discrepancy. This may involve contacting parents/guardians, the GP, or paediatrician who prescribed the medicine, the pharmacist who supplied the medication or consulting previous records to help clarify administration requirements.

4.5 An account of this process should be recorded in detail on the child's Daily Record Sheet along with any conversations, outcomes or verbal instructions offered regarding the administration of the medication.

4.6 It must be acknowledged that on occasions, due to specific health conditions, a child may require a variable dosage of their prescribed medication, which is not practicable to record on a label e.g. lactulose for constipation. Where the child is receiving respite care,

it is the responsibility of the parents/carers to give written instructions to the care home/respite home clearly stating a minimum and maximum dose and when/under what circumstances carers should adjust the dose of medication. For example a parent/carer may specify that an additional dose of lactulose should be given if the child does not open their bowels for a certain period of time. Once written instructions are received the care worker should check the BNF (British National Formulary) to ensure the dose falls within that recommended for children. If a care worker is unhappy with the dose the parent has specified, then contact should be made with the prescriber for clarification or the child's paediatrician.

4.7 Where a child is placed within the full time care of the local authority, care staff should ensure that where variable dosage medication is required, clear details of the circumstances of administration should be clarified in writing with the prescriber and recorded clearly on the child's **Medication Advice Record (Form A)**.

4.8 In the case of respite care, on occasions the child's Paediatrician/GP may alter a child's dose of medication, however due to the timing of the respite, the parent/carer is unable to immediately arrange for a change of label. In such circumstances, a GP/Paediatrician's letter to the respite home detailing the dose change is permissible for a period of up to 7 days to allow for labels to medication to be changed. Should the carer/respite provider be unhappy, contact should be made with the prescriber for clarification.

4.9 Out of date medication should not be administered and should be disposed of by returning the medication to the dispensing pharmacist, or parents where a child is receiving respite care. Parents/Guardians should be informed of any such actions.

4.10 When such medication is essential contact should be made with either the child's parents, GP/Pharmacist for replacement. If out of hours, further advice should be sought via NHS Choices or the AE Department at the Manor Hospital.

4.11 Providing there are no discrepancies, or discrepancies have been resolved, details of the child's medication should be entered onto the **'Prescribed Medication Administration and Discharge Record' (Form B)**.

a. Child's full name
b. Child's date of birth
c. Child's full address
d. Name of child's GP

h. Name of medication and route of administration
i. Dose of medication in mg
j. Strength of medication
k. Number of tablets or volume

e. Telephone number of child's GP
f. Any known allergies / reactions
g. Date the medication was received
l. Quantity In
m. Signatures

4.12 **'A Prescribed Medication Administration Record' (Form C)** should be completed detailing each prescribed drug. The following must be recorded: type of medication /strength, the dose to be administered, exact times to be taken, (please note this may not be possible with variable dosage medication) and time of administration.

4.13 Once this has been completed for each prescribed drug, the form should be placed on the child's medication file. Any preceding record sheet should be filed in the child's working file.

N.B New forms B, C, D or E as appropriate must be utilised every time a child is admitted. Form A must also be reviewed at each admission for accuracy. Where children are looked after on a full time basis Form A must be reviewed at least 6 monthly or as medication circumstances change.

5. Administration of Medication

5.1 **Self Administration**

Self administration of medication must be risk assessed with children in conjunction with relevant health care professional and parents/carers where possible. This assessment must be written in consultation with relevant health professionals and may consider a range of factors including:

a. Age

b. Level of understanding of child

c. Type of medication

d. History and lifestyle factors

5.2 If the child is permitted to administer his/her own medication, the arrangements for this must be agreed with the social worker, and set out in the child's Residential Placement Plan.

5.3 In cases where the child may administer their own medication this must also be recorded on **'Medication Advice Record' (Form A, Part 1)**.

5.4 Arrangements should be made to ensure that the child self administers their medication appropriately and as such the dose and amount should be checked with the child and recorded on the **Prescribed Medication Administration Record (Form C)** or in the case of non prescribed medication, the **Non Prescribed Medication Record' (Form E)**.

5.5 Where concerns arise that a child is not self administering or storing their medication correctly, a further self administration of medication risk assessment must be completed in conjunction with the child, social worker, parents/carer and relevant health professionals.

6. Administration of Medication by Staff

6.1 The administration of medication should not be used as a form of social control or punishment.

6.2 Medication prescribed for one child should not under any circumstances be given to another child or used for a different purpose.

6.3 Two trained members of staff are required to be present and attentive throughout the process of medication administration. Staff administering medication must not be interrupted during the process.

6.4 The following process should be carefully followed by the staff:

6.5 Carefully check the identity of the child and ensure that you have the correct **'Medication Administration Record' (Form C)** or **'Non Prescribed Administration Form' (Form E)** for this child by checking the name on the form.

6.6 Identify that the **'Prescribed Medication Administration Record' (Form C)** or **'Non Prescribed Administration Form' (Form E)** is current by checking the dates.

6.7 Check the Medication and Dosage instructions are clear and understood, if not, check with parent/carer if contactable, a manager, a GP, the Paediatrician or Pharmacist. Do not administer any medication until medication, dosage and instructions are clarified.

6.8 It is important that staff check that the medication has not already been given. This can be checked on the **''Non Prescribed Administration Form' (Form E)** or the **Prescribed Medication Administration Record' (Form C)**. If there is any doubt do not administer further medication until the situation is clarified.

6.9 Unlock the drugs cabinet, identify the child's medicine bottles(s) / containers(s) checking that the labels and information on the 'Medication Administration & Discharge Record Form' (Form B or Form D) match.

6.10 The member of staff responsible for administering medication (giver) must measure/count the correct dosage, this must be witnessed by a colleague (witness) for each dose of medication given, at all times staff must ensure the correct medication is being given to the right person as directed.

6.11 Every drug administered must be signed for separately on the corresponding **'Prescribed Medication Administration Record' (Form C)** or the **'Non Prescribed Administration Form' (Form E)**. Staff should:

i. Check that the name of the medication recorded on the 'Prescribed Medication Administration Record' (Form C) or the 'Non Prescribed Administration Form (Form E) corresponds with the drug administered

ii. Check the dose administered

iii. Check the time the dose is due to be administered

iv. The date

v. Record the time the dose is actually administered

vi. Ensure that the 2 signatures are in the correct box on Form C or Form E which corresponds with the correct date and time

This must be done immediately after medication has been given to the child.

6.12 If a child refuses to take medicine, staff should not force them to do so.

6.13 If medication is refused or not administered for any reason this must be recorded on the **'Prescribed Medication Administration Record' (Form C)** or the **'Non Prescribed Administration Form' (Form E)**, clearly stating the reason. This should be recorded on the child's daily record sheet and the Manager informed. At Eldon House this information should be passed on to the parents/guardians also.

6.14 If a child at any home is repeatedly refusing medication then a manager should be informed. In cases of repeat refusal of medication, staff must ensure that the child's Social Worker, parents / carers, the medication prescriber and relevant health professionals are notified to ensure the level of risk is assessed and recorded. Where appropriate parents should be involved in any on-going plans or agreements.

6.15 Staff must ensure at all times that medication is handled with care and diligence and containers and bottles are kept clean.

6.16 Where prescribed medication is not administered, the non administration must be clearly recorded on Form C with the reason for non administration, as per key at foot of form.

7. Invasive Procedures

7.1 Children and young people on medication such as **Buccal Midazolam** or **Rectal Diazepam** for epilepsy must have an up to date risk assessment and procedure to follow in emergencies. Staff administering Buccal Midazolam, Rectal Diazepam or medication via a gastrostomy tube must have been assessed as competent by a registered nurse within the previous 12 months.

7.2 **Gastrostomy / Tube Feeding**

Staff must be trained in gastrostomy feeding before undertaking any tasks. The procedures must only be practiced following full and appropriate training by identified professional medical/nursing staff from the Health Authority. Annual refresher training must be undertaken.

7.3 The procedures must be used in conjunction with the children's residential placement plans/health care plan which must clearly identify the correct procedures, equipment, feeding regimes, stoma care, emergency response procedures and emergency contact numbers.

7.4 A risk assessment regarding tube feeding must be present on the individual child's file.

7.5 Staff must not attempt to replace a gastrostomy tube unless they have received training to replace a gastrostomy tube and have been signed off by a medical professional as competent to carry out this task for the named child in an emergency situation only. Medical advice must be sought immediately.

7.6 **Rectal Diazepam and Midazolam**

Staff must be trained in the administration of rectal diazepam and midazolam before undertaking any tasks. The procedures must only be practiced following full and appropriate training by identified professional medical/nursing staff from the Health authority. Annual refresher training must be undertaken.

7.7 The procedure must be used in conjunction with the children's residential placement plans/health care plans which must be clearly identify the nature of the epileptic fit, medication, emergency treatment procedures and emergency contact numbers.

7.8 A risk assessment on rectal diazepam and midazolam must be present on the individual child's file.

7.9 Any home required to administer rectal diazepam and midazolam to a child must ensure that the parents or guardian have contributed to an epilepsy assessment and completed a consent form.

8. Handing Over Medication Between Shifts

8.1 Details of all medication, prescribed and non prescribed must be formally passed over between duty staff at every handover including those that happen between day and night staff.

8.2 Handovers of medication must cover:

- The types and quantities of medication held on the premises / being handed over;
- Which children require medication during the next shift;
- What medication each child requires, dosage and when;
- Any refusal of medication and action taken/required;
- That recording is up to date and accurate.

8.3 The handover of medication must be recorded and signed for in the handover book.

8.4 Subsequent shift planning must take account of the arrangements for the administration of medication on that shift.

8.5 **Holiday or Leave Medicines**

If a child/young person is going on holiday or leave, the child's original dispensed medicines or a separately dispensed supply of medicines should be used. Medication must not be placed in envelopes or other types of containers. Any medicines leaving or entering the home for the purposes of leave/holidays/outings should be appropriately recorded.

9. Discharging Medication

9.1 On the day the child is discharged from the home, a person responsible for administration of medication and a witness **must** together:

9.2 Identify medication belonging to the child by checking labels and matching this against the **'Prescribed Medication Administration & Discharge Record' (Form B)** or the **'Non Prescribed Administration Form' (Form E)**.

9.3 Record the amount being released (quantity out column) on the **'Prescribed Administration & Discharge Record' (Form B)** or the **Non Prescribed Administration & Discharge Record (Form D)**. Check this is correct by going through **'Prescribed Medication Administration Record' (Form C)** or the **'Non Prescribed Administration Form' (Form E)** checking the number of days, the person receiving medication and amount given each day. Subtract this from the amount received to ensure the amount being released is correct by counting up number of tablets or estimating volume of liquid.

9.4
i. Any discrepancies must be reported to a manager to investigate
ii. Record date medication released on the **'Prescribed Medication Administration & Discharge Record' (Form B)** or the **'Non Prescribed Administration Form' (Form E)**
iii. Person releasing medication must sign the **'Prescribed Medication Administration & Discharge Record' (Form B)** or **'Non Prescribed Administration Form' (Form E)**
iv. Witness also to sign the **'Prescribed Medication Administration & Discharge Record' (Form B)** or **'Non Prescribed Administration Form' (Form E)**

N.B. When a child is discharged from a children's home, 2 trained members of staff (one checker / one witness) should record and check the amount of medication; reconciling the number of tablets and volume of liquids being released and returned with the child on the date the care episode ends.

10. Disposal of Medication

10.1 All medication supplied on prescription must be disposed of as per it's expiry date, once it is completed or after 28 days from it's last administration, if it is no longer required.

10.2 A designated member of staff should check the medical cabinets on a monthly basis to ensure all medication is currently in use, it is all within its use by date and all medication held within the cabinet is prescribed to the current resident group.

10.3 Any prescribed medication that is not within these criteria should be disposed of. To ensure continuity staff must ensure that the child has a continuous prescription and that the prescription is filled on time.

10.4 Medication for disposal should be returned to the pharmacist, and this should be recorded on the **'Prescribed Medication Administration & Discharge Record' (Form B)** or the **'Non Prescribed Administration Form' (Form E)** and the **'Prescribed Medication Administration Record' (Form C)** or the **'Non prescribed Medication Administration' (Form D)**.

10.5 Medicines should not be disposed of within the home, a pharmacist should always be used, preferably the pharmacist who supplied the medication.

10.6 Special arrangements should be made for the disposal of any “sharp” material, such as needles or sugar level testing kits. Bins are supplied on prescription for diabetic patients or by hygiene suppliers (Cannon).

10.7 Any home / common remedies should be checked regularly to ensure they are within the recommended dates.

10.8 All common / homely remedies should be returned to the pharmacy for disposal when out of date or no longer required.

11. Storage of Medication

11.1 **General Storage**

All prescribed medication stored for a child must be kept in a secured lockable cupboard, with a double lock system. Ideally there should be individual sections available to store each child’s medication separately. Controlled medication must be stored separately from prescribed/non prescribed medication (See Section 12).

11.2 Where a child is self administering medication they should be encouraged to keep this secure within their room. Medication risk assessments must take into account that some medications have to be kept close to or on a child’s person (e.g. inhalers, Epipen) due to the nature of the illnesses being treated.

11.3 Keys to medicine cabinets should be kept (when not in use) in a locked key cupboard.

11.4 When administering medication the officer responsible for administering the medication should have responsibility for the secure storage of keys.

11.5 **Cold Storage**

A separate, dedicated, lockable refrigerator should be available to store medications which require cold storage. This refrigerator should be used exclusively for the storage of medicines and should be kept locked at all times. A record of the fridge temperature must be recorded twice daily and should be between 2 – 8°. The refrigerator should be defrosted regularly.

11.6 **Checks must be made to ensure that medication does need to be refrigerated. If not it may be harmful to the user.**

11.7 Should the home have to store insulin, then this should be kept within the refrigerator. However, it should be away from the freezer box and the walls of the refrigerator.

11.8 All medication must be stored in a hygienic and clean environment, not prone to extreme temperature changes. Medication must not be stored in a bathroom, toilet or sluice room. Medication cabinets must be cleaned regularly.

11.9 Expiry dates should be noted as certain items i.e. eye drops, once opened lose their sterility and must be used within a set time e.g. discard 28 days after opening in order to maintain sterility.

11.10 Any home/common remedies held within the home should be stored, as prescribed medicines, within a locked cabinet.

11.11 When children are self administering medication they should be able to store their medication/ointment in lockable cupboards/drawers to allow for safe storage. All children should have a secure lockable cupboard/safe for use within their rooms. Staff should be able to access this in the case of an emergency.

11.12 Should children refuse to do this, then their ability to self-administer should be re-assessed due to the risk this may present to themselves and the other children within the home.

11.13 All unwanted/unused medication should be disposed of immediately. It should not be kept with medication currently being used as this could possibly lead to incidents of the wrong medication being administered. This is more likely to happen if the same child has received several prescriptions over a short period of time, and the course of treatment has not been completed.

11.14 If a child has to receive regular on-going medication and qualifies under The Disability Discrimination Act (DDA) the pharmacist must supply a monitored dosage system (MDS). In other circumstances a MDS may be supplied but only where it is in the interests of the child. Advice on monitored dosage systems can be sought from the child's GP or pharmacist.

12. Controlled Drugs

12.1 Controlled drugs (CDs) are prescribed medicines that are usually used to treat severe pain, induce anaesthesia or treat drug dependence and they have additional safety precautions and requirements. Some are also used in other situations, for example, methylphenidate (RitalinTM) is used in the treatment of attention deficit hyperactivity disorder (ADHD). Some people abuse CDs by taking them when there is no clinical reason to do so.

12.2 There are legal requirements for the storage, administration, records and disposal of CDs. These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). They do not apply to every social care service and they do not apply when a person looks after and takes their own medicines.

There has been a high profile given to managing CDs since the Shipman Inquiry published the fourth report in 2004, all social care services are recommended to have special arrangements for CDs even though the law does not currently require it.

- Examples of CDs are morphine, fentanyl and methylphenidate
- Storage cupboards for CDs are available commercially. Secure storage is required when a care home looks after CDs and keeps them centrally. If patients look after their own CDs then these drugs must be stored in a locked draw or bedside cabinet
- Hard bound registers are recommended for CD records

12.3 **Obtaining Controlled Drugs**

CDs are prescribed and dispensed for individually named people, in the same way as other medicines.

- There are special legal requirements for CD prescriptions so you should always allow extra time for these to be written
- A prescription that does not comply with these requirements may have to be sent back to the prescriber for altering before it can be dispensed
- If a care worker collects CDs from a pharmacy on behalf of someone else, they will be asked to provide identification

12.4 **Records for Controlled Drugs**

Residential social care settings for adults should keep a separate record of the receipt, administration and disposal of CDs. It is good practice for records of this type to be kept in children's homes.

- Administration should be recorded both on the Medicine Administration Record Charts (MAR) and in the CD record book
- These records must be kept in a bound book with numbered pages
- There should be a separate page for each CD for each person
- Include the balance remaining for each product. This should be checked against the amount in the pack or bottle at each administration and also on a regular basis e.g. monthly.

- Any discrepancy must be reported to the Registered Manager of the home who should consult with relevant health professionals and their line manager regarding further action required. This may include the Clinical Commissioning Group (CCG) accountable officer: Dr Sam Ramaiah, Jubilee House, Bloxwich Lane, Walsall, WS2 7JL. Tel: 01922 618388

In order to determine the Schedules of CDs for which these records should be kept please refer to the **List of Drugs Currently Controlled under the Misuse of Drugs Legislation**.

12.5 **Disposal of Controlled Drugs**

Special arrangements apply to the disposal of CDs in care homes registered to provide nursing care in England and Wales:

- If supplied for a named person; denature CDs using a kit designed for this purpose and then consign to a licensed waste disposal company

- If supplied as a ‘stock’ for the care home (nursing): two authorised persons must witness the disposal

For all other social care settings, the CDs should be returned to the pharmacist who supplied them at the earliest opportunity for safe denaturing and disposal. When CDs are returned for disposal, a record of the return should be made in the CD record book. It is good practice to obtain a signature for receipt from the pharmacist.

12.6 Some pharmacies may treat the return of CD’s for disposal as a ‘general patient’ return and as such may initially be unwilling to sign for receipt of the CD.

12.7 In order to give a CD you should follow all the steps involved in giving any other medicine (Section 6). In residential settings it is good practice if a second appropriately trained member of staff witnesses the process.

12.8 Please be aware there may be rules around the transport of controlled drugs where the CD is not being transported with the patient. Prior to transporting CD’s please contact the CCG accountable officer: Dr Sam Ramaiah, Jubilee House, Bloxwich Lane, Walsall, WS2 7JL, Tel: 01922 618388.

12.9 **Care Planning for Administration of CD’s**

Residential placement plans for individual children who are prescribed controlled drugs must be clear regarding arrangements for the receipt, administration, transportation and disposal of the CD’s.

13. Reporting and Investigation of Errors and Near Misses

Whilst the aim of this procedure is to minimise the likelihood of medication errors, in the event that a medication error does occur, the first priority is to ensure the safety and welfare of the child and that appropriate health care advice is sought and any necessary treatment is given as soon as possible. Depending on the circumstances, seeking advice and assistance could range from contact with NHS Choices, a pharmacist, or GP, to a request for emergency services. In all circumstances a manager, or in the case of out of hours, the on-call manager, should be advised, their first priority being to ensure the safety and welfare of the child concerned.

13.1 Once the child's safety and welfare has been secured staff should make a written report of the error on **Form G (Record of Medication Errors or Near Misses)** and make it available for the attention of the Registered Manager of the home. This report must be completed prior to the staff concerned leaving duty.

13.2 Upon receiving a written report regarding a medication error, the Registered Manager should immediately review the report and arrange for a detailed assessment to be undertaken without delay into how the error occurred and what measures need to be taken to strengthen medication arrangements, and reduce the risk of any further errors.

13.3 Depending on the nature of the error this assessment could involve discussions with the staff involved in the error, staff who noticed the error and a review of documents such as shift plans, training records, daily records, child's health information and medication records. All assessments in respect of medication errors should involve consultation with relevant health professionals i.e. Looked After children's Nurse, Community Sister for Respite etc. to ensure a health care perspective, transparency and appropriate arrangements are actioned to reduce the risk of further errors.

13.4 Recommendations arising from a detailed assessment of a medication error must be shared with the staff team and implemented as soon as possible to reduce the risk of any further errors.

13.5 The child's Social Worker and parents/guardian (if appropriate) should be advised as soon as possible following any medication error.

13.6 It should be acknowledged that the identification and assessment of near misses can help to reduce the risk of a medication error occurring. As such where staff identify a near miss, this should also be recorded on **Form G (Record of Medication Errors or Near Misses)** for the attention of the Registered Manager.

13.7 As with medication errors the Registered Manager should immediately review the report and arrange for a detailed assessment to be undertaken without delay to determine any action needed to strengthen medication arrangements and reduce the risk of error. All

assessments in respect of near misses should involve consultation with relevant health professionals i.e. Looked After Children's Nurse, Community Children's Nurse etc. to ensure a health care perspective, transparency and appropriate arrangements are actioned to reduce the risk of errors.

13.8 Recommendations arising from the detailed assessment of a near miss must be shared with the staff team and implemented as soon as possible to ensure the risk of errors is reduced.

13.9 Copies of all detailed assessments and recommendations arising from medication errors or near misses should be kept securely by the Registered Manager and a running log of incidents **Medication Error / Near Miss Incident Log (Form H)** maintained to ensure transparency and enable analysis of any patterns or trends.

14. Roles and Responsibilities

Staff Induction, Training and Responsibilities

Staff must:

- Not administer medication until they are fully inducted and trained
- Have read and understood this policy
- Keep clear and accurate records in accordance with legislative guidance and this policy
- Ensure and monitor their own competence in current medication administration techniques and take responsibility for their own personal development
- Acknowledge the importance of administering medication and ensure giver and witness are not interrupted during the process
- Ensure discrepancies are clarified to ensure that children receive appropriate care. In the case of respite care, it must be acknowledged that respite care is valuable to both children and families and as such children should only be sent home or parents/carers called in to administer medication in the most extreme of circumstances and where a risk assessment indicates safe care is not viable otherwise
- Ensure that a comprehensive residential placement plan / health plan exists for every child and that it contains appropriate medical information and details in what circumstances contact should be made with parents / carers
- Administer medication as required to individual children in accordance with this policy
- Report errors and near misses as soon as they are identified
- Ensure they attend work able to give medication safely i.e. alert and fresh

- Ensure a diligent and attentive approach to the administration of medication is taken and maintained
- Ensure a comprehensive and accurate verbal, face to face and written handover of medication is undertaken at each handover
- Ensure that they attend First Aid training as required and that any First Aid Treatment given is recorded clearly in the child's Daily Record and handed over to colleagues coming on to duty

Employer / Manager Responsibilities

- Ensure all staff are inducted in this policy including arrangements for:
    - The storage of medication
    - Administering medication
    - Record keeping in respect of the receipt, administration, discharge and disposal of medication
    - Recording medication information in the health care plans / residential placement plans for individual children
- Ensure the provision of adequate training to all staff administering medication including 2 yearly training from a trained pharmacist (i.e. nominated pharmacist for the home or Boots Pharmacist)
- Ensure that all staff are trained in the use of First Aid. A one day course covering First Aid for Children must be undertaken and there should be no less that one First Aider on shift at all times
- Ensure the review and evaluation of staff performance and required training in relation to this medication policy in accordance with probationary, supervision and appraisal processes
- Ensure regular reviews of the policy on medication administration
- Investigate errors and near misses in line with this procedure
- Ensure that their insurance arrangements provide full cover in respect of actions which could be taken by staff in the course of their employment – Risk & Insurance Services can provide up to date information and certification
- Ensure that there are appropriate systems for sharing information about children's medical needs in each setting for which they are responsible
- Undertake monthly medication audits to ensure compliance to this procedure

Parents / Carers – Respite Care

- Give written information regarding variable dosage medication with GP/Paediatrician guidance
- Take part in all aspects of health care planning in relation to their child in a timely manner
- Ensure labels are up to date, correct and legible
- Ensure, where possible, that patient information inserts are handed over with medication
- Ensure any changes to doses are accompanied with a current GP/Paediatrician letter where time does not allow for a change to labels
- Ensure only the medication/amounts of medication needed for the stay in question are given to the home
- Consent to the administration of prescribed and non prescribed medication as per this policy

15. Acknowledgements

Children's Residential Services are indebted to the members of the Task Group for their invaluable work in formulating this Policy:

The Task Group Consisted of:

Alison Glover	Group Manager – Children's Residential Services
Sharon Guy	Residential Manager – Lichfield Road Children's Home
Lois Stevens	Residential Manager – Redruth Road Children's Home
Dr P Carter	Community Consultant Paediatrician
Suzanne Rimmer	Head of Children's Specialist Services
Robert Saunders	Prescribing Adviser (LTC)
Jola Forys	Community Children's Nurse
Deborah Goodridge	Community Children's Nurse, Mary Elliot School

Rachel Harvey	Community Children's Nurse, Looked After Children & Respite
Theresa Tunnel	Parent Representative

Appendix 1 - Controlled Drugs List

The following is a list of the most commonly encountered drugs currently controlled under the misuse of drugs legislation showing their respective classifications under both the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. **Although it is extensive, the list is not exhaustive** and, in the event of a substance not being listed below, reference should also be made to the notes in Parts I, II, III and IV of Schedule 2 to the Misuse of Drugs Act 1971 and in Schedules 1 to 5 to the Misuse of Drugs Regulations 2001. Reference may also be made to Home Office Licensing Section (at **licensing_enquiry.aadu@homeoffice.gov.uk**) who hold a more detailed list of drugs in Schedules 1 and 2 and to the Laboratory of the Government Chemist.

The list was taken from the **Home Office website**.

Acetorphine A 2 Acetyldihydrocodeine B 2/5 Acetylihydrocodeinone A 2 Adanon A 2 Alfentanil A 2 Allobarbital B 3 Allobarbitone B 3 Allyl(alpha-methyl-3,4-methylenedioxyphenethyl)amine A 1 Allylprodine A 2 Alphacetylmethadol A 2 Alphameprodine A 2 Alphamethadol A 2 Alphaprodine A 2 Alpha-3-Acetoxy-6-Methylanino-4,4-Diphenylheptane A 2	Beta,2,5-Trimethoxy-4-methylphenethylamine A 1 Beta,3,4,5-Tetramethoxyphenethylamine A 1 Beta-Methoxy-3,4-methylenedioxyphenethylamine A 1 Betaprodine A 2 Bezitramide A 2 Blue Mystic A 2 para 1(d) Bolandiol C 4 Pt 2 Bolasterone C 4 Pt 2 Bolazine C 4 Pt 2 Boldenone C 4 Pt 2 Bolenol C 4 Pt 2 Bolmantalate C 4 Pt 2 Bromazepam C 4 Pt 1 Bromo-STP TABS A 1

Alpha Methyl Fentanyl A 1 (d)

Alpha-Methyl-3,4-methylenedioxyphenethyl(prop-2-ynyl)amine A 1

Alpha-Methyl-4-(methylthio)phenethylamine

(also known as 4-Methylthioamphetamine) A 1

Alpha-Methylphenethylhydroxylamine (also known as

N-Hydroxyamphetamine) B

Alpha,Alpha-Dimethyl-3,4-methylenedioxyphenethylamine A 1

Alpha,Alpha-Dimethyl-3,4-methylenedioxyphenethyl

(methyl)amine A 1

Alpha-Methylfentanyl A 1 (d)

Alphacetyl Methadd A 2

Alphenal (5-Ally-5-Phenylbarbituric Acid) B 3

Alprazolam C 4 Pt 1

Amidone A 2

Amobarbital (See amylobarbitone)

Amphetamine B• 2

mylobarbitone B 3

Amylobarbitone Sodium B 3

Anhydroecgonine HCL A 2

Anhydroecgonine Methyl A 2

Anileridine A 2

Any 5,5 disubstituted barbituric acid B 3

Aprobarbital B 3

Bufotenine A 1

Buprenorphine C 3

Butalbarbital B 3

Butalibtal (Fiorinal) B 3

Butallylonal B 3

Butethal B 3

Butobarbital B 3

Butobarbitone B 3

Calusterone C 4 Pt 2

Camazepam C 4 Pt 1

Cannabinol B 1

Cannabinol Crystalline B 1

Cannabinol derivatives (except dronabinol or its derivatives) B 1

Cannabis and cannabis resin B 1

Cannabis oil - derived from herbal cannabis B 1

Cannabis oil - derived from cannabis resin

Carbon-14 Labelled Dextropropoxyphene C 2

Carfentanil A 2

Cathine C 3

Cathinone C 1

Cense Dal neal Barbitone B 3

Chlordiazepoxide C 4

Chorionic gonadotrophin (HCG) C 4 Pt 2

Chlorphentermine C 3

Clenbuterol C 4 Pt 2

Cliradon A 2

Aprobarbitone B 3	Clobazam C 4 Pt 1
Atamestane C 4 Pt 2	Clonazepam C 4 pt 1
BDB A 1	Clonitazene A 2
Barbital B 3	Clorazepic acid C 4 Pt 1
Barbitone B 3	Clostebol C 4 Pt 2
Barbitone sodium B 3	Clotiazepam C 4 Pt 1
Barbituric acid, (any 5,5 disubstituted) B 3	Cloxazolam C
Benzethidine A 2	4 Pt 1
Benzoylecgonine-Isopropyl Ester A 2	Coca leaf A 1
Benzphetamine C 3	Cocaethylene A 1
Benzyl(alpha-methyl-3,4-methylenedioxyphenethyl)amine A 1	Cocaine A 2/5.
Benzylmorphine (3-benzylmorphine) A 2	Codeine B• 2/5.
Betacetylmethadol A 2	Codeine Linctus B 5
Betameprodine A 2	Concentrate of poppy straw A 1
Betamethadol A 2	Co-Proxamol C 2/5

Cyclobarbital B 3	Estazolam C 4 Pt 1
Cyclobarbitone B 3	Ethchlorvynol C 3
Cyclobarbitone calcium B 3	Ethinamate C 3
Cyclopentobarbitone B 3	Ethnine
Cyclopropylmethyl(a-methyl-3,4-methylenedioxyphenethyl)amine A 1	Ethyl-1-(2-(2 hydroxyethoxy)ethyl)-4-phenylpiperidine-
D3-Codeine B 1	4-carboxylate A 2
D3-Morphine A 2 para 1	Ethyl-l-(3-hydroxy-3-phenlpropyl)-4-phenylpiperidine-
D-Amphetamine Sulphate B 2 para 6	4-carboxylate A 2
D-DL-3-Acetoxy-6-methylamino-4,4-diphenyl	

heptane A 2

DL-L-Phenyl-2-Aminopropane B 2

D-Lysergic Acid Methyl Proplamide A 1 para a

D-Lysergic Acid N-(Methylopropyl) Amide A 1

Delorazepam C 4 Pt 1

Delta-Tetrahydrocannabinol – D3 B 1 para 1(c)

Delta-1-Tetrahydrocannabinol B 1

Delta-8-Tetrahydrocannabinol (or Delta-8-THC) B 1

Delta-9-Tetrahydrocannabinol (or Delta-9-THC) B 1

Deoxyephedrine Hydrochloride B 2 para 6

Desomorphine A 2

Dexedrine B 2

Dextroamphetamine Sulphate B 2

Dextromoramide A 2

Dextropropoxyphene C 2/5.

Dextrostat (Dextroapphetamine Sulphate) B 2

Dexyephedrine B 2

DHEA (dehydroepiandrosterone) (**see** prasterone)

Diacetylmorphine A 2

Diallybarbituric Acid B 3

Diamorphine A 2

Diapromide A 2

Diazepam C 4 Pt 1

1Diethylpropion C 3

Diethylthiambutene A 2

Ethyl loflazepate C 4 Pt 1

Ethylmethylthiambutene A 2

Ethylmorphine (3-ethylmorphine) B• 2.

Ethyloestrenol C 4 Pt 2

Eticyclidine A 1

Etonitazene A 2

Etorphine A 2

Etoxeridine A 2

Etryptamine A 1

Eucodal A 2

Fencamfamin C 4 Pt 1

Fenethylline C 2

Fenproporex C 4 Pt 1

Fentanest A 2

Fentanyl A 2

Fludiazepam C 4 Pt 1

Flunitrazepam C 3

Fluoxymesterone C 4 Pt 2

Flurazepam C 4 Pt 1

Formebolone C 4 Pt 2

Fungus (of any kind) which contains psilocin or an ester of psilocin A 1

Furazabol C 4Pt 2

Furethidine A 2

Glutethimide B 2

HBDB N-Methyl-1-(3,4 methylene dioxyphenyl)-2-

butananmine-1-(4-bromo-2,5-dimethoxy)-2-

Difenoxin (1-3-cyano-3,3-diphenylpropyl

-4-phenylpiperidine-4-carboxylic acid) A 2/5.

Dihydrocodeine B• 2/5.

Dimethyl(alpha-methyl-3,4-methylenedioxyphenethyl)amine A 1

Dehydroepiandrosterone (**see** prasterone)

Drug Class Schedule

Diclofenac Acid ester of Morphine A

Dihydrocodeinone A 2

Dihydrocodeinone-0-carboxymethyloxime A 2

Dihydromorphine A 2

Dihydromorphine 3,6-Diglucuronide A 2

Dimenoxadole A 2

Dimepheptanol A 2

Dimethyl(alpha-methyl-3,4-methylenedioxyphenethyl)amine A 1

Dimethylthiambutene A 2

Dioxaphetyl butyrate A 2

Diphenoxylate A 2/5.

Dipipanone A 2

DI-P-Chloro Methamphetamine B 1 para 1(c)

DI-P-Chloroamphetamine B 1 para 1(c)

D-Norpseudoephidrine C 3

Dronabinol (Delta-9-THC) B 2

Drotebanol (3,4-dimethoxy-17-methylmorphinan- 6b, 14-diol) A 2

Drostanolone C 4 Pt 2

Durogestic Patches A 2

ethanamine A 1(c)

HMMA (4-hydroxy-3-methoxy methamphetamine) A 1 para 1(c)

Halazepam C 4 Pt 1

Haloxazolam C 4 Pt 1

Heptobarbitone B 3

Hexadeuterated Diamorphine A 2

Hexethal sodium B 3

Homoveratrylamine or 2 (3,4-dimelhoxyphenyl) A 1

Hydrocodone (dihydrocodeinone) A 2

Hydromorphan A 2

Hydromorphinol A 2

Hydromorphone A 2

Hydroxypethidine A 2

Ibomal B 3

Isocodeine B 2

Isomethadone Hydrochloride A 2

Ketamine C 4 Pt 1

Ketazolam C 4 Pt 1

Ketobemidone A 2

Lefetamine B 2

Lero-a-acetylmethadol A 2

Levo-a-acetylmethadol Alpha Methadyl Aceate A 2

Levomethorphan A 2

Levomoramide A 2

Levophenacylmorphan A 2

Durophet (Riker) B 2 Ecgonine (& any derivative of ecgonine which is convertible to ecgonine or to cocaine) A 2 Ecstacy (MDMA) A 1 Enantiomer d-threo-methylphenidate B 2 Enestebol C 4 Pt 2 Epitiostanol C 4 Pt 2	Levorphanol A 2 Lofentanil A 2 Loprazolam C 4 Pt 1 Lorazepam C 4 Pt 1 Lormetazepam C 4 Pt 1 Luminal B 3 Lysergamide A 1

Lysergic Acid N-(Methylopropyl) Amide A 1 Lysergic Acid N, N Methylpropylamide A 1 Lysergide (& other N-alkyl derivatives of lysergamide) A Marinol A 2 Mazindol C 3 MBDB A 1 para 1(c) MDA A 1 MDEA A 1 MDMA A 1 Mebolazine C 4 Pt 2 Mecloqualone B 2 Medazepam C 4 Pt 1 Medicinal opium A 2/5. Mefenorex C 4 Pt 1 Meperidine A 2 para 1 Meperidinic Acid A 1	N Methyl Lysergic Acid Diethylamide A 1 N-(2,5-Dimethoxy-4-propylthiophenthyl)hydroxylamineA 1 N-(4-Ethylthio-2,5-dimethoxyphenethyl)hydroxylamine A 1 N-(4-sec-Butylthio-2,5-dimethoxyphenethyl)hydroxylamine A 1 N-Benzylpethidine A 1 para(e) N-ethylamphetamine C 4 Pt 1 N-Hydroxyamphetamine (also known as Alpha-Methylphenethylhydroxylamine) B 2 N-hydroxy-tenamphetamine A 1 N-Hydroxy-Methylenedioxyamphetamine HL A 1 N-Methylhomoveratrylamine A 1(C) N-Methyl-N-(alpha-methyl-3,4-methylenedioxyphenethyl) hydroxylamine A 1 N-Methyl-1-(3-4-Methylenedioxyphenyl)-2-

Mephentermine C 3 Mephobarbital B 3 Mepitiostane C 4 Pt 2 Meprobamate C 3 Mesabolone C 4 Pt 2 Mescaline A 1 Mestanolone C 4 Pt 2 Metazocine A 2 Mesterolone C 4 Pt 2 Me+A525adate B 2 Methadone A 2 Methadyl acetate A 2 Methamphetamine / Methylamphetamine A 2 Methandienone C 4 Pt 2 Methandriol C 4 Pt 2 Methaqualone B 2 Methcathinone A 1 Methenolone C 4 Pt 2 Methoxydimethyltryptamine A 1 Methylamphetamine / Methamphetamine A 2 Methyldesorphine A 2 Methyldihydromorphine (6- methyldihydromorphine) A 2 Methylecgonidine A 2 Methylegonine Base & HCL A 2 Methylene Dioxythyl Amphetamine A 1 para 1(c) Methylene-dioxymethyl-amphetamine (MDMA) A	Butanamine A 1 para 1(c) N,N-diethyltryptamine A 1 N,N-Dimethyl-IH-Indole-3- Ethanamine A 1 N,N-dimethyltryptamine A 1 N-Omega- Methyltryptamine A 1(b) Nandrolone C 4 Pt 2 ealbarbitone B 3 Nicocodine B• 2/5. Nicodicodine (6-nicotinoyldihydrocodeine) B• 2/5. Nicomorphine (3,6-dinicotinoyl- morphine) A 2 Nimetazepam C 4 Pt 1 Nitrazepam C 4 Pt 1 Non-human chorionic gonadotrophin C 4 Pt 2 Noracymethadol A 2 Norboletone C 4 Pt 2 Norclostebol C Norcocaine A 2 para 1 Norcodeine B• 2/5. Nordazepam C 4 Pt 1 Norethandrolone C 4 Pt 2 Norlevorphanol A 2 Normeperidine A 1 Normethadone A 2 Normorphine A 2 Normorphine Hemisuccinide A 2

1 Methylenedioxy-amphetamine (MDA) A 1 Methylenedioxyethylamphetamine (MDEA) A 1 Methylphenidate B• 2 Methylphenobarbitone B 3 Methyltestosterone C 4 Pt 2 Methyprylone C 3 Metopon A 2 Metribolone C 4 Pt 2 M-Hydroxbenzaylecgonine A 2 M-Hydroxycocaine, P-Hydroxycocaine A 2 Mibolerone C 4 Pt 2 Midazolam C 3 Morpheridine A 2 Morphine A 2/5. Morphine3, 6-diacalte A 1 Morphine-3-acetate A 3 Morphine-3-B-D-Glucoride-N-Oxide A 3 Morphine-3-B-D-Glucuronide A 2 Morphine-6-acetate A 3 Morphine-6-B-D-glucuronide-N-oxide A 3 Morphine-6-Sulphate A 2 para (4) Morphine methobromide (& morphine N-oxide& other pentavalent nitrogen morphine derivatives) Morpholinylethylmorphine B 2/5 Myrophine A 2	Norpipanone A 2 Norpseudoephedrine C 3 O-Methyl-N-(alpha-methyl-3,4- methylenedioxyphenethyl) hydroxylamine A 1 Opium: - raw A 1 - prepared or medicinal A 2/5 Ovandrotone C 4 Pt 2 Oxabolone C 4 Pt 2 Oxandrolone C 4 Pt 2 Oxazepam C 4 Pt 1 Oxazolam C 4 Pt 1 Oxycodone A 2 Oxymesterone C 4 Pt 2 Oxymetholone C 4 Pt 2 Oxymorphone A 2 Oxymorphone-3-Glucuronide A 2 P.Bromophenethylamine A 1 (c) P-Fluorophenethylamine A 1 (c) P-Hydroxybenyleceonine A 2 Paderyl B 5 Pemoline C 4 Pt 1 Pentazocine B 3 Pentobarbital B 3 Pentobarbitone B 3 Pentobarbitone calcium B 3

	Pentobarbitone sodium B 3 Pethidine A 2 Pethidine Intermediate A A 2 para 1

Phanodorm (Cyclobarbitone) B 3 Phenadoxone A 2 Phenampromide A 2 Phenazocine A 2 Phencyclidine A 2 Phendimetrazine C 3 Phenmetrazine B• 2 Phenobarbital B 3 Phenobarbitone B 3 henobarbitone sodium B 3 Phenomorphan A 2 Phenoperidine A 2 Phentermine C 3 Phenylethylamines & Relative Compounds A 1 1(c) Phenylmethylbarbituric acid B 3 Pholcodine B• 2/5. Physeptone A 2 Piminodine A 2	Secbutobarbital B 3 Secbutobarbitone B 3 Secbutobarbitone sodium B 3 Secobarbital (See quinalbarbitone) Secobarbitone (See quinalbarbitone) Seconal Mixture B 2 Silandrone C 4 Pt 2 Sodium Amytal B 3 Somatotropin C 4 Pt 2 Somatrem C 4 Pt 2 Somatropin C 4 Pt 2 Stanolone C 4 Pt 2 Stanozolol C 4 Pt 2 Stenbolone C 4 Pt 2 Sufentanil A 2 Talbutal B 3 Temazepam C 3 Tenocyclidine A 1 Testosterone C 4 Pt 2

Pinazepam C 4 Pt 1

Pipradrol C 3

Piritramide A 2

PMS-G (Pregnant Mare Serum-Gonadotrophin) C 4

Poppy straw A N/A

Potassium Clorazepate C 4 Pt 1

Prasterone C 4 Pt 2

Prazepam C 4 Pt 1

Probarbitone calcium B 3

Probarbitone sodium B 3

Proheptazine A 2

Properidine (1-methyl-4-phenyl-piperidine-4-carboxylic acid isopropyl ester) A 2

Propetandrol C 4 Pt 2

Propiram B 2/5.

Propoxyphene C 2

Propylbenzoylecganine A 2

Proxibarbital B 3

Psilocin A 1

Pulmo Bailly (cough medicine) B 5

Pyrovalerone C 4 Pt 1

Quinalbarbitone B 2

Quinalbarbitone sodium B 2

Quinbolone C 4 Pt 2

Racemethorphan A 2

Racemoramide A 2

Tetrahydrocannabinol – THC B 1

Tetrazepam C 4 Pt 1

Thebacon (acetyldihydrocodeinone) A 2

Thebaine A 2

Thiomesterone C 4 Pt 2

Tilidate A 2

Tilidinum A 2

Trenbolone C 4 Pt 2

Triazolam C 4 Pt 1

Trimethoxyamphetamine A 1

Trimeperidine A 2

Tylenol no3 B 5

Valaron (also known as Tilidinum and Tilidate Hydrochloride) A 2

Veramon (Barbitone – Amidopyrine comd) B 3

Vinbarbitone B 3

Vinbarbitone sodium B 3

Vinylbital B 3

Vinylbitone B 3

Ziperol A

Racemorphan A 2 Raw opium A 1 Rolicyclidine A 1 Roxibolone C 4 Pt 2	