



Royal College  
of Nursing

# In-flight medicines: guidance for management and administration



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# Introduction

There is significant confusion around issues of drug administration in the in-flight or aeromedical setting. High profile cases, such as the Shipman Inquiry (2004), have resulted in a reassessment of current practices and all practitioners holding a UK Nursing and Midwifery Council registration must ensure compliance with UK law at all times.

The administration of medicines is a central role of all registered nurses and midwives, and there are few circumstances when nurses can administer medicines without a prescription or authorisation by another practitioner with the authority to prescribe. Nurses prescribing, supplying, or administering medicines must do so within the law, and the focus must always be on the patient – with safety being paramount.

In response to the heightened regulation around medicines and medicines management, every practitioner, employer or provider of health care or medical assistance needs to review their own clinical governance arrangements around the supply, administration, documentation and management of medicines to ensure compliance with current regulations.

To support this, the RCN Critical Care and In-Flight Nursing Forum is producing competences around clinical practice and knowledge which will encompass medicines and medicines management.

This guidance aims to clarify the issue of medicines management and the administration of medicines in the in-flight setting, and advises on the best practice required to work within the current UK law at time of writing.

The aim of this guidance paper is to clarify the issues around drug administration by outlining:

- the classes and categories of medicines and the implications of these
- the practice and legal issues around drug administration
- the risks associated with drug administration in the in-flight environment
- the options for best practice to enhance patient care and maintain safety.

## The law and medicines

Medicines control was an early activity of the European Economic Community (EEC), with the first basic EEC directive to control medicines being introduced in 1965. In 1973 the UK joined the EEC and at that time the controls on medicines (under the Medicines Act of 1968) matched or in some cases exceeded those of existing European directives. As a result the UK played a major part in the development and revision of EEC directives in this area.

In 1995, UK legislation was brought into line with European Community (EC) legislation relating to marketing authorisations, labelling and leaflets. The key laws in the UK governing the use of medical products, and which influence practice are:

- *The Medicines Act 1968*
- *The Misuse of Drugs Act 1971*
- *The Misuse of Drugs Regulations 2001*
- *May 2006 – Extension of Non-Medical Prescribing.*

However, in relation to the treatment of patients mid-flight it is crucial that practitioners are aware of, and follow, the laws of the country they are operating in or governed under.

## The Medicines Act 1968

*The Medicines Act 1968* (HMSO, 1968) controls the production and supply of medicinal products. Its primary purpose is to ensure drugs and medicines are safe and produce their desired effect, when compared to a placebo. The act also incorporates a legal requirement to categorise medical products as follows:

- general sales list medicines (GSL) must be sold or supplied in the manufacturer's original pack
- pharmacy medicines (P)
- prescription only medicines (POM)
- controlled drug (CD).

These categorisations denote how medicines can be prescribed and supplied:

- the categorisation of GSL medicines allows for sale and supply without any medical supervision, such as in a shop or garage
- a pharmacist without a prescription can supply a P category medicine
- a medicine in the POM category can only be prescribed by a registered doctor, nurse, or allied health professional with the legal authority to prescribe medicines
- while medicines classed specifically as CDs carry additional restrictions, it is vital to understand that some P and POM medicines are also classed as CDs (any medicines containing CDs, such as codeine or benzodiazepines), and there are often additional requirements for these particular medicines.

It is also worth noting that some drugs have different categorisations dependent on their indications and dosage: an example of this is aspirin (acetylsalicylic acid); at 300mg for general headaches and pains it has a GSL category, but for its anti-platelet effects at 75mg it has a P classification.

## The Misuse of Drugs Act 1971

*The Misuse of Drugs Act 1971* (HMSO, 1971) primarily deals with the issues of production, possession or trafficking of drugs scheduled on the act; the act controls a vast list of drugs which is divided into classes and schedules.

## Drug classes

*The Misuse of Drugs Act 1971* (HMSO, 1971) categorises drugs into three classes – A, B and C – for criminal purposes. As such, a drug will have a criminal classification as well as a controlled schedule classification under the *Misuse of Drug Regulations*.

**Table 1: Adapted from the Misuse of Drugs Act 1971**

CLASS CATEGORY		
A	B	C
Morphine Fentanyl	Codeine	Temazepam Traizolam Co-proxamol Diazepam

## Drug schedules

*Controlled drugs: amendments to the Misuse of Drugs Regulations 2001* (Home Office, 2005) divides controlled drugs (CDs) into five schedules, corresponding to their therapeutic usefulness and misuse potential.

Schedule 1 contains medicines with little or no medicinal use (such as cannabis) while Schedules 2 to 5 include medicines with a risk of abuse; Schedule 2 contains morphines and diamorphines, while Schedule 5 includes some low dose opiates which are less likely (although not entirely) to be abused.

While Schedule 5 medicines therefore require the least controls – indeed some are available in over-the-counter products sold in the UK – in other countries these medicines may have a higher controlled classification or may even be outlawed. It is therefore vitally important to ensure medicines taken into other countries are legal there, and that possession does not pose a risk of prosecution for the practitioner.

**Table 2: Adapted from the Misuse of Drugs Regulations 2001**

SCHEDULE				
1	2	3	4	5
Opium (raw) Cannabis LSD	Controlled drugs including opiates (morphine, diamorphine) and major stimulants such as amphetamines	Barbiturates (except quinalbarbitone)	Benzodiazepines, anabolic and androgenic steroids and some related hormones	Controlled drugs with a lower risk of abuse compared to other schedules. Includes preparations of cocaine and morphine: common medicines in this range include codeine * co-codapin, co-codamol and co-dydramol, oromorph 10mg/5ml

**Table 2 notes:**

\*Some medicines may fall into one or more schedules depending on the strength of the controlled drug in the medicine and the form (oral or injectable). As such, there are restrictions on carriage and administration of such drugs.

**Schedule 1**

Drugs in Schedule 1 are the most stringently controlled and cannot be prescribed by doctors or dispensed by pharmacists (such as cannabis, LSD, opium).

**Schedule 2**

It is illegal to possess drugs in Schedule 2 without a prescription or other authority. Drugs in this schedule include opiates (morphine, diamorphine) and major stimulants such as amphetamines. A Home Office licence is required to produce, import, export or supply substances in this schedule.

**Schedule 3**

It is illegal to possess drugs in Schedule 3 without a prescription or other authority. Drugs in this schedule include barbiturates and major stimulant drugs. A Home Office licence is required to export or import and authority is required for production, possession and supply.

**Schedule 4**

No prescription or other authority is required to legally possess drugs in Schedule 4, so long as these are in the form of a medicinal product. No licence is needed to import or export Schedule 4 drugs, but authority is required for production and supply. Drugs included in this schedule include benzodiazepines, and anabolic and androgenic steroids.

**Schedule 5**

Schedule 5 contains the drugs that are considered to pose minimal risk of abuse. These noninjectable small dose preparations can sometimes be purchased over the counter at a pharmacy without prescription (as a P category medicine) or may alternatively be a Prescription Only Medicine (POM) therefore requiring a prescription. Once obtained it is illegal for them to be supplied to another person. Many of these preparations include well-known cough mixtures and painkillers. This Schedule includes preparations that have small doses of opiate based ingredients including codeine, dihydrocodeine, cocaine and morphine.

Common medicines in this schedule include co-codamol, co-codamol, and oromorph 10mg/5ml. The classification may depend on the strength of the controlled substance in the preparation.

## The administration of scheduled drugs

Section 7 of *Controlled drugs: amendments to the Misuse of Drugs Regulations 2001* (Home Office, 2005) states:

‘Any person may administer to another any drug specified in Schedule 5. A doctor or dentist may administer to a patient any drug specified in Schedule 2, 3 or 4. Any person other than a doctor or dentist may administer to a patient, in accordance with the directions of a doctor or dentist or nurse *with holding an appropriate non-medical prescribing qualification under a clinical management plan*, any drug specified in Schedule 2, 3 or 4.’

This, in essence, is a patient specific direction (PSD).

There are now 13 medicines classed as controlled drugs, limited to specific conditions, which independent nurse prescribers can prescribe to a patient. For example, morphine/diamorphine can be prescribed in cases of palliative care, trauma, cardiac or post operative pain.

## Professional issues

The Nursing and Midwifery Council (NMC) is responsible for the regulation of nursing and midwifery practice and the provision of professional standards designed to protect the public, which are enshrined in its *Code of Professional Practice* (NMC, 2008).

In relation to the administration of drugs, the NMC has issued guidance around the standards for proficiency of nurse and midwifery prescribing, and has separate standards for medicines management. However, this guidance document does not and cannot cover all aspects of nursing practice, but outlines the broad principles for practice. The key issues for in-flight nurses are that any administration of medicines should comply with:

- principles in relation to the prescription
- principles for the administration of medicines
- record keeping aspects
- self-administration of medicines.

The NMC publications – *Standards and proficiency of nurse and midwifery prescribers* (NMC, 2006) and *Standards for medicines management* (NMC, 2007) – are available to view and download from the NMC website at [www.nmc-uk.org](http://www.nmc-uk.org)

## Prescribing issues

Unless a registered nurse holds an independent or supplementary prescribing qualification, all medicines that require administration by that registered nurse *must be prescribed in all cases against a prescription or authority to prescribe by a doctor or another practitioner with the authority to prescribe.*

In the hospital setting this can be against a ward drug chart, or by electronic prescribing. The ward drug chart is a combined *written direction* and administration record. For medicines to be taken home, a separate written prescription to take away (TTA) or outpatient department (OPD) prescription) is written and dispensed by a pharmacy.

Outside the hospital setting medicines may be prescribed by using an FP10, FP10HP, and private prescription. This currently applies to only doctors, dentists, and accredited professionals with a prescribing qualification – such as nurses and pharmacists.

## Homely remedy protocols

These protocols allow a nurse to administer GSL drugs – such as paracetamol – outside the NHS. The protocols are limited to drugs on the GSL list only, and the format is similar to a patient group direction (PGD). An example of a homely remedy protocol (HRP) for paracetamol can be found at Appendix C.

## Patient group direction (PGD) – clarification

*PGDs as per HSC 2000/026 (England), WHC (2000) 116 (Wales), HDL (2001) 7 (Scotland)*

The Department of Health (DH) has defined a patient group direction (PGD) as:

‘A written instruction for the supply or administration of medicines (or medicines) where the patient may not be individually identified before presenting for treatment. A PGD is drawn up by doctors, pharmacists and other health professionals and must meet certain legal criteria. Each PGD must be signed by a doctor or dentist, as appropriate, and a pharmacist, and approved by an appropriate body, usually a Primary Care Trust (PCT) or NHS trust’ (NHS and DH, 2006).

A PGD only applies when used in the following health provider settings:

- NHS
- independent hospitals, agencies and clinics registered under *The Care Standards Act 2000 (HMSO, 2000)*
- prison health care services
- police services
- defence medical services.

Therefore a PGD is not a legal option for the in-flight setting, unless the health institution or provider is one of the above and meets the criteria set down. If a PGD is not permissible then a patient specific direction (PSD) may be used.

It should also be noted that PGDs are not suitable where a range of different medicines need to be given to a patient at the same time.

## Patient specific direction (PSD) clarification – the traditional solution

A PSD is ‘a written instruction from a doctor or dentist for a medicine or appliance to be supplied or administered to a named patient.’

Therefore, a PSD is an *authority to administer medication*. In the hospital setting a ward drug chart is effectively a PSD: it is an authority to administer a drug. The chart also supports the requirement to record the administration.

The DH defines a PSD as ‘a traditional written instruction from a doctor, dentist or nurse prescriber, for medicines to be supplied or administered to a named patient. The majority of medicines are still prescribed and supplied using this process, but as a PSD is individually tailored to the needs of a single patient it should be used in preference to a PGD (patient group direction) wherever appropriate’ (DH, 2005).

In the in-flight setting a drug administration chart designed for a specific patient would suffice as a PSD, provided it is authorised with a signature by a doctor or other health professional with the authority to prescribe medicines. A suggested example of a PSD suitable for in-flight can be found at Appendix A.

## Nurse prescribing

A registered nurse (RN) can only legally prescribe and administer a medicine once they have followed a period of theoretical education and practical observation to gain a prescribing qualification. The NMC records such prescribing qualification on the NMC register against registrants’ names and other recordable qualifications; these qualifications can be checked via the NMC website at [www.nmc-uk.org](http://www.nmc-uk.org).

## Independent prescribing

An independent prescriber takes responsibility for the clinical assessment of a patient, establishing a diagnosis and the clinical management required, as well as prescribing where necessary and the appropriateness of any prescription. It is ideal where the nurse is remote from the doctor.

There are currently two types of independent nurse prescriber: registered community nurse prescribers and independent nurse prescribers.

### Registered community nurse prescribers

Following training, a Registered Specialist Community Public Health Nurse (RSCPHN), formerly district nurses and health visitors, may prescribe from a limited formulary of products designed to meet the needs of patients. This consists of appliances, dressings and some medicines – including 13 prescription only medicines (POMs) some pharmacy (P) and general sales lists (GSL) medicines. Since April 2002 this qualification can be used outside of these specialities, as long as the practitioner has the agreement of their employer.

Details of this formulary are set out in both the *British National Formulary* (BMA and RPS, 2004)). The appropriate preparation for prescribing from this Formulary is now incorporated into the basic training of all RSCPHNs.

### Independent nurse prescribers

Since 2002 all first level registered nurses and registered midwives may now train to prescribe from the *Nurse Prescribers Extended Formulary* (NPEF) (DH, 2010). The NPEF originally included:

- all medicines in the *Registered Specialist Community Public Health Nurses Formulary* (RSCPHN) (formerly DN/HV)
- all licensed pharmacy (P) medicines and all general sales list (GSL) medicines that can be prescribed at NHS expense (excluding controlled drugs)
- a range of around 180 prescription only medicines (POMs).

These medicines were only to be prescribed for use in the following four therapeutic areas:

- minor illness
- minor injury
- health promotion
- palliative care.

However, nurses are no longer restricted by a list of conditions and are now able to prescribe any licensed or unlicensed medication for any condition – with the exception of certain controlled drugs – provided they are practicing within their competence.

Details of the NPEF, including a full list of indications for which nurses may prescribe, are set out in both the BNF and the Part XVIIB (ii) of the Drug Tariff (DH, 2011).

## Nurse supplementary prescriber

Despite the recent changes that have expanded the BNF for nurse prescribing, supplementary prescribing still remains and maybe more appropriate for nursing staff expanding their initial prescribing role. This method of prescribing may also be more suitable for patients with polypharmacy needs, or where the prescribing of unlicensed medicines or controlled drugs is required.

Supplementary prescribing is defined as ‘a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber’, to implement an agreed patient-specific clinical management plan with the patient’s agreement. Supplementary prescribing was introduced for first level registered nurses and registered midwives from April 2003, and other professionals such as physiotherapists and pharmacists also use this mechanism for prescribing.

There are no legal restrictions on the clinical conditions that may be treated under supplementary prescribing, although the Department of Health would normally expect supplementary prescribing to be used for the management of chronic medical conditions and health needs.

There is no specific formulary or list of medicines for supplementary prescribing. Provided medicines are prescribable by a doctor or dentist at NHS expense, and are referred to in the patient’s clinical management plan, supplementary prescribers are able to prescribe:

- all general sales list (GSL) medicines and all pharmacy (P) medicines
- appliances and devices prescribable by GPs
- foods and other borderline substances approved by the Advisory Committee on Borderline Substances
- all prescription only medicines (including controlled and licensed medicines as of April 2005).

The inclusion of controlled drugs in a clinical management plan was subject to amendments to the *Misuse of Drugs Act* (HMSO, 1971) and *Controlled drugs: amendments to the Misuse of Drug Regulations 2001* (Home Office, 2005) which became law on 14 March 2005.

## Off label prescribing

With regard to using medicines outside their licensed indications (‘off label’ prescribing), ‘black triangle’ drugs, and drugs marked ‘less suitable for prescribing’ in the BNF, nurses now qualify with both independent prescriber and supplementary prescriber qualifications. Further detailed information on supplementary prescribing can be found on the DH website at [www.dh.gov.uk](http://www.dh.gov.uk)

As a result the options for in-flight nursing practice are wider than current custom and practice allows, as such nurses who hold an independent prescribing qualification can, where governed by UK law, authorise the administration of medicines, including the writing of private scripts, against the widened *Drug Tariff* (DH, 2011).

A doctor or nurse with a prescribing qualification can authorise a PSD provided they have assessed the patient; this may be by telephone, medical records/notes, but patient safety must be seen as paramount.

## Medicines supplied and administered through exemptions to the Medicines Act

There are a number of exemptions to the Medicines Act (HMSO, 1968) (where UK law is valid), but only a few are of consequence to in-flight nursing staff. One such exemption allows a member of HM Forces to supply and or administer medicines where these persons are satisfied that it is not practicable for another person who is legally entitled to supply/administer a prescription only medicine to do so; and only in so far as is necessary for the treatment of a sick or injured person in a medical emergency, or to prevent ill-health where there is a risk that a person would suffer ill-health if the prescription only medicine is not supplied or administered.

Further information on this exemption is contained in *The Medicines (Exemptions and Miscellaneous Amendments) Order 2009* (HMSO, 2009).

Another relevant exemption to the Medicines Act is explained in further detail in the Administrations of medicines in an emergency section below.

## Civil and criminal liability in the handling of medicines

The administration of medicines is integral to the role of the registered nurse/midwife, as part of the care plan necessary to maintain health. To practice effectively practitioners need to be able to work with medicines, but also to work within the law. While administering a medicine under an agreed

protocol for an assistance company, employer or other organisation, the practitioner remains legally accountable for her/his actions. However, the employing organisation also assumes vicarious liability for the actions of the practitioner.

Vicarious liability is the term applied to a situation where an employer is held to be civilly liable for the negligent acts or omissions of its employee, not based on any fault of the employer. If there is a close connection between the nature of the employment and the negligence in question, the employer will be liable for the employee's negligence. In other words, if the negligence can fairly be regarded as a reasonably incidental risk to the type of business undertaken by the employer, the employer will be liable.

Both practitioners and the employing organisation must also appreciate the risks they face if they fail to observe the law regulating the supply and administration of medicines. Under the *Misuse of Drugs Act 1971* (and amendments) the possession and supply of controlled drugs outside of the law may lead to criminal prosecution and, if convicted, the offender may be sentenced to a substantial fine and even imprisonment.

Prosecutions under *The Misuse of Drugs Act* (HMSO, 1971) may be brought against the individual practitioner, the company and any director, manager, secretary or other similar officer of the company. Equally, a practitioner may face proceedings before her/his professional body – the NMC – with the ultimate sanction of being struck off the register.

It is critical therefore that any nurse who carries and administers a medicine is both confident that he or she can undertake the task to the appropriate standard of care, and does so within the terms of a written protocol devised in strict compliance with the relevant legislation.

## Carriage of controlled drugs into the UK

HM Revenue and Customs (HMRC) has issued guidance on the amount of controlled medicines prescribed by a doctor which can be carried by a patient back into the United Kingdom, without the need for a licence. This guidance – *Taking medicines when you go abroad* (HMRC, 1998) – lists the quantity of controlled substance that can be carried by the patient. Any amount above this requires a licence.

Should the patient be carrying medicines above the specified amounts, the HMRC needs to be notified and an application to carry such medicines is required. While there is no standard application form to apply, the information the HMRC requires in the form of letter from a doctor giving details to support the application includes:

- the patient's name and current address
- the quantities of drugs to be carried
- the strength and form in which the drugs will be dispensed
- the dates of travel to and from the UK.

Nurses who are required to carry controlled drugs in Schedules 2 and 3 – such as fentanyl and morphine for critical care needs – need to apply to the Home Office for a license to do so. Further information is available from the Home Office website at [www.homeoffice.gov.uk](http://www.homeoffice.gov.uk).

## Carriage of controlled drugs into other countries

Every country decides which medicines are classified as controlled and in the European Community, there is one register. While there tends to be common similarities in European Union (EU) regulations, some medicines which are classified on a lower schedule by UK regulations may be more restricted in another EU state. It is the responsibility of each registered practitioner to be aware of what medicines or drug substances are restricted and what is required prior to carriage into that country.

Some countries treat the carriage of controlled drugs very seriously, with serious and harsh penalties including death sentences on some occasions.

It is essential to check the customs websites of the relevant countries to assess whether the medicines you may be carrying have any controlled elements, and what documents or regulations are required to carry such items. Ideally the question should be “is this medicine necessary at this time?”.

## Administration of drugs in an emergency

In the event of a patient deteriorating in your care, you have a professional duty of care to respond appropriately within your sphere of competence. As such, this may mean the administering of medicines in a life saving emergency without the authority to prescribe. An example of this might be a cardiac arrest, requiring administration of drugs such as ephifeningine (adrenaline) or atropine.

While a non-prescribing nurse would not be allowed to prescribe such medicines, these may be accessed from the airline or airport or other emergency resuscitation stock and then could be administered provided you follow appropriate actions – such as providing or supervising appropriate life support.

The law makes provision for such life saving events and excludes the need for a prescription.

### Exemptions to the Medicines Act

The *Prescription Only Medicines (Human Use) Order 1997* (TSO, 1997) lists medicines for circumstances including a life saving emergency; a list of these medicines can be found in Appendix B.

In these circumstances, under the *Code of Professional Practice* (NMC, 2008) you would be acting appropriately as failure to do so could be seen as neglect of duty.

The possession of an Advanced Life Support (ALS) course in itself does not provide the authority to administer first line drugs in a peri or cardiac arrest situation. The issue, from the perspective of the law of negligence, is that the practitioner has the knowledge, skills and experience to undertake the role in accordance with an acceptable standard of care. A certificate (whether for basic or advanced life support) may be ‘evidence’ of competence in this regard, but it is not a necessary a precondition of practice.

## Indemnity insurance and RCN representation

The RCN provides indemnity insurance for nurses provided they can demonstrate they have the appropriate training and skills, and work within the *Code of Professional Practice* (NMC, 2008)

In representing members, the RCN Critical Care and In-Flight Nursing Forum recognises that while there are solutions to the administration of medicines from a UK perspective it requires lobbying of the Department of Health and the Home Office on the situation to highlight the complexities of practicing in this environment.

While we cannot give authoritative information on restrictions in other countries, registered nurses in the UK – unless they hold a registration in another country – cannot legally practice as a nurse; however by actively engaging in in-flight practice they must also practice within the requirement and standards of the *Code of Professional Practice* (NMC, 2008)

Future advanced practice is likely to require nurses to hold prescribing qualifications, and have these registered with the NMC. In-flight nursing providers need to recognise such practitioners enhance patient care and ensure seamless care by having such competencies.

## Summary

The UK legislation quoted within this document applies to areas governed by UK law, and where UK law governs practice. It is the responsibility of the practitioner to be aware of the laws of the country they are working under, and to understand that legislation relating to controlled drugs and nurse prescribing may not apply.

Current custom and practice in relation to the carriage and administration of medicines in the in-flight setting needs review, in line with best practice and clinical governance, by each registered nurse and each organisation in the in-flight setting. This provides a safeguard to the registered nurse, the organisation and most importantly the patient.

Nurses cannot prescribe medicines for any person, including other passengers or relatives, unless they have undergone appropriate training and have a recorded prescribing qualification on the NMC register. While they can always give advice, that advice must not be seen as prescribing, and they are accountable for any advice given. It would be advisable to record such instances.

Nurses can administer medicine provided it is authorised by protocol or prescribed, and ideally it is the patient's own medicine being carried by or on behalf of them. In the event that a nurse in the in-flight setting needs to administer a medicine that the patient is currently not prescribed by their GP, the nurse will need to have a written protocol (depending on the provider they are working for) and ensure they are administering within the law.

In exceptional circumstance, nurses can administer some medicines in an attempt to save life, provided it is within one of the drugs listed in Appendix B. It is recommended that any instance of this is documented clearly, and many airlines may require a statement of such.

All nurses need to ensure they are working within the principles of the NMC guidance on drug administration at all times, and document all medicines administered including those self-administered by the patient.

The RCN Critical Care and In-Flight Nursing Forum endorse best practice and will actively lobby for in-flight nurses to access programmes to allow nurse prescribing qualifications.

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### Useful websites

British National Formulary (BNF) [www.bnf.org](http://www.bnf.org)

HM Revenue and Customs [www.hmrc.gov.uk](http://www.hmrc.gov.uk)

National Prescribing Centre (NPC) [www.npc.co.uk](http://www.npc.co.uk)

National Electronic Library for Medicines [www.nelm.nhs.uk](http://www.nelm.nhs.uk)

Information about supplementary and independent prescribing can be found on the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk)

Information on drug policy and licensing can be found on the Home Office website at [www.homeoffice.gov.uk](http://www.homeoffice.gov.uk)

## Appendix A: Example of a patient specific direction (PSD) for in-flight (adult)

Unique Identifier/Case Number	Patient's Name	DOB				
Prescribing/Authorising RMO/Dr:		GMC No:				
Date of Prescription:						
RN/M Name:		NMC No:				
Drug	Dosage/ Route/Method	Dosage/Time/Route/Administered				
Example E.g. Metoclopramide	10mgs/tds/IM	X	X	X	X	X

Any registered nurse/midwife administering medicines under a PSD must ensure they have:

- assessed the patient for any allergies or sensitivities; if so, do not administer
- checked for contraindications and compatibility with other current medications using a current BNF
- documented all the above
- documented any refusal, or non-administration or self-administration in the patient's medical records and any reasons why administration has not occurred.

Administering a medicine outside of a PSD (including to another person not named on the authority) may result in the registered nurse/midwife not being covered by the organisation's/assistance company's vicarious liability.

## Appendix B: List of drugs that may be given in an emergency without prescription

This extract from Article 7 of the Statutory Instrument No.1830 (1997) *Prescription only medicines (human use) order 1997* contains details of the drugs that may be administered for ‘the purpose of saving life in an emergency’.

Exemption for parenteral administration in an emergency to human beings of certain prescription only medicines

7. The restriction imposed by section 58(2)(b) (restriction on administration) shall not apply to the administration to human beings of any of the following medicinal products for parenteral administration –

Adrenaline Injection 1 in 1000 (1 mg in 1 ml)  
 Atropine Sulphate Injection  
 Atropine sulphate and obidoxime chloride injection  
 Atropine sulphate and pralidoxime chloride injection  
 Atropine sulphate, pralidoxime mesilate and avizafone injection  
 Chlorphenamine Injection  
 Dicobalt Edetate Injection  
 Glucagon Injection  
 Glucose Injection 50%  
 Hydrocortisone Injection  
 Naloxone Hydrochloride  
 Pralidoxime chloride injection  
 Pralidoxime mesilate injection  
 Promethazine Hydrochloride Injection  
 Snake Venom Antiserum  
 Sodium Nitrite Injection  
 Sodium Thiosulphate Injection  
 Sterile Pralidoxime

where the administration is for the purpose of saving life in an emergency.

## Appendix C: Example of a homely remedy protocol (HRP) – options appraisal (adapted for in-flight with permissions)

### DRUG: PARACETAMOL (Adults)

#### Definition of clinical condition/situation:

- Supply of paracetamol to provide pain relief or pyrexia

#### Criteria, which exclude the patient from treatment:

- Known sensitivity to any component if the formulation of paracetamol to be administered
- Children under 12 years of age
- Known liver disease

#### Action to be taken for this group of patients

- Refer/discuss patients to medical officer

#### Name of medicine to be supplied/administered without direct medical supervision:

- PARACETAMOL

#### Legal Status (P, GSL)

- GSL

#### Dose to be used, and where applicable, criteria for deciding dose and frequency:

- Adults over 12 years of age: 1 gram – where there is evidence following assessment if mild/moderate pain or pyrexia over 37.5 c
- Dose may be repeated every 4–6 hours following initial administration with a maximum of 4 doses in a 24-hour period
- Duration of this protocol may not exceed 24-hours without the referral of a doctor

#### Route of administration:

- Oral

#### Total (maximum) number of doses:

- 4 doses of 1 gram in 24-hour period

#### Advice to be given to patient/carer:

- For dissolvable, mix with water
- For all formulations do not take with any other formulation of paracetamol
- Ensure that the maximum recommended dose of 4 grams in 24-hours is NOT exceeded

#### Identification and management of adverse outcomes:

- Rashes may rarely occur

#### Arrangements for referral for medical advice:

- Non-urgent – review by GP via appointment system
- Urgent – contact RMO or other medical support immediately for urgent advice

*Source: Northgate and Prudoe NHS Trust Sept 2004 (Adopted with BNF input)*



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