Medicines Overarching Framework

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Contents

1 Introduction

Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines. Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare.

2 Why we need this policy

2.1 Purpose

The purpose of this policy is to define the procedures to be followed within the Trust for the prescribing, dispensing, storing, administering and disposal of medicines in order to protect service users and staff against the risks associated with unsafe use and management of medicines.

2.2 Objectives

The objectives of this policy are to:

- To ensure that people who use our services will have their medicines at the times they need them, and in a safe way by
    - Handling medicines safely, securely and appropriately
    - Ensuring that medicines are prescribed and given safely
    - Following published guidance about how to use medicines safely

3 Scope

3.1 What this policy applies to

For the purpose of this policy, the term ‘medicines’, whether for internal or external use, applies to:

• Controlled drugs controlled under the provisions of the Misuse of Drugs Act 1971, with stringent requirements for supply, storage and administration.
• All other medicines and medicinal products prepared for administration to patients and which are controlled by the Medicines Act 1968. This also includes many diagnostic agents, and medical gases.
• All complementary medicines e.g. aromatherapy, herbal or homeopathic remedies. These products are used for therapeutic purposes and require the same safeguards as other medicines.
• Medicated dressings and nutritional products.

3.2 Who this policy applies to

- All staff working within the Trust who are involved, in some way, with the use of medicines. It also includes medical, nursing and other staff from other NHS Trusts, the Local Authority or from the private sector, who are contracted to work in TEWV on a sessional basis.

TEWV staff working within other organisations must follow the medicine policies and procedures relating to that organisation being mindful of their obligation to adhere to their professional codes of conduct and standards of practice.

3.3 Roles and responsibilities

Role	Responsibility
All staff involved with the use of medicines	• Familiarising themselves with the correct procedures contained in this policy framework.
Chief Pharmacist	• The Trust's designated senior pharmacist responsible for the organising, monitoring and reporting of a system for assuring the safe and secure handling of medicines.
Local Authority Staff	• Local Authority staff working in integrated community teams must follow this policy in relation to the safe and secure handling of medicines in addition to complying with their own organisational policy requirements. Staff who have roles in which involvement of medicines has been identified must undertake trust training on safe and secure handling of medicines.
Medical Staffing Department	• Providing a record of appointment and signature of all prescribers (including locum appointments) to the Chief Pharmacist which is updated with any changes in appointments.
Medical and non-medical prescribers	Doctors and suitably qualified nurses, pharmacists and other designated healthcare professionals are responsible for: • Having up-to-date clinical, pharmacological and pharmaceutical knowledge relevant to own area of practice. • Making or reviewing a diagnosis, generating management options for the patient and following up management • Establishing relationships with patients based on trust and mutual respect. Recognising patients as partners in the consultation. • Being aware of own limitations and not compromising patient safety. • Ensuring prescribing practice is consistent with scope of practice, organisational, professional and regulatory standards, guidance and codes of conduct. • Actively participating in the review and development of prescribing practice to optimise patient outcomes. • Understanding and working within local and national policies, processes and systems that impact on prescribing practice. Seeing how own prescribing impacts on the wider healthcare community. • Knowing how to access relevant information. Being able to use

	and apply information in practice.
Practitioners/Appointed Practitioner in Charge	• Responsible for the stock of all medicines held and ensuring that policies and procedures to manage the risks associated with the use of medicines are followed. • Maintaining the security of medicines and ensuring that stocks of controlled drugs, if held, correspond with the details shown in the register. • Administration of medicines. • Where administration of medicines is delegated to a Designated Practitioner, the Appointed Practitioner in Charge is responsible for ensuring the Designated Practitioner has received the relevant training and experience before being allowed to take on responsibility for medicine procedures. • Practitioners in training must be given every opportunity to become proficient in medicines related activities under appropriate supervision. Delegation and lines of responsibility should be clearly defined. The supervising Designated Practitioner has responsibility for medicine procedures at such times. • Understanding and working within their scope of practice.
Ward/Department Managers	• Ensuring that their staff, especially new starters and locum staff, follow these procedures; • Managers who contract services must make it explicit within the written contract that sessional or contracted staff must follow this policy and related procedures. • Provide a record showing appointment and signature of all Appointed Practitioners in Charge and qualified staff authorised to request medication to the Chief Pharmacist which is updated with any changes.
Nursing associates	• NAs can administer medication via oral, enteral, topical, intramuscular, subcutaneous, inhalation routes and administer enemas and suppositories in line with a valid prescription with the following exceptions/caveats: o administration of insulin o NA can only administer to those titrated/established on depot medication. o The only as required (PRN) medication that NAs can administer currently are any that are prescribed within the homely remedies section of the prescription chart.
Non registered practitioners (NRPs) and allied health professionals (AHPs)	• Checking receipt and stock checks, and witnessing administration of controlled drugs with a Designated Practitioner where controlled drug witness training has been completed. • Administering medicines to specific patients in identified circumstance following competency training as detailed in local procedures. • NRPs may assist Practitioners with the administration of sip feeds and non-medicated creams and ointments when directed

	to do so. Responsibility for correct identification of the patient and administration of the correct preparation remains with the Practitioner. • NRPs and AHPs who have completed the safe and secure handling of medicines training may deliver medication if identified as part of their role in the treatment of patients. • NRPs who have a designated role running clozapine clinics without PocHi machines may be authorised by the Designated Practitioner in Charge to access the medicines cupboard for the sole purpose of issuing clozapine supplies to patients which have been dispensed following a green result.
Trust Pharmacy Staff	• Advising on the safe, effective and economic use of medicines including advising practitioners on the storage of medicines in clinical areas. • Inspecting the stocks of medicines held on the ward or department at any time to ensure the medicines are in date and stored under the proper legal and environmental conditions.
Trust Clinical Pharmacists	• Advising on and monitoring the safe, effective and economic use of medicines • Reviewing the medication history of patients • Providing a medicine information service for staff, patients and carers • Advising patients on their use of medicines • Monitoring for medicine interactions/adverse reactions and whether the therapy is achieving the desired therapeutic end points • Reviewing pharmaceutical information on Forms T2/T3 • Monitoring reports of medication incidents • Supporting and undertaking reconciliation of medicines Clinical pharmacists may annotate the drug prescription and administration record. This annotation should ensure the approved name, dose, route and precautions are included on the prescription, to guide practitioners when they administer the medicine. The Appointed Practitioner in Charge should agree with the pharmacist and consultant the arrangements for advising patients about their medicines.
Trust Pharmacy Technicians	• Reviewing ward medicine stocks • Ordering medicines to ensure continuity in supply and prevention of omitted doses • Monitoring medicines to make sure they are safe and securely handled and correctly stored • Assessing patient's requirements for compliance aids • Counselling patients on medication • Liaising with the pharmacies providing the supply and dispensing service to the Trust under contract

	• Replenishing and monitoring emergency drug bags • Assessing patient's own drugs for suitability for use • Processing unwanted medication from wards and departments • Supporting and undertaking reconciliation of medicines • Providing compliance/reminder sheets for patients Pharmacy technicians who have undertaken basic clinical and accuracy check of prescription and administration chart competency checks may annotate the drug prescription and administration record chart. This annotation should ensure that mandatory information is complete.
Trust Pharmacy Administration and Clerical staff	• Providing a ward top up service to designated wards in the Trust • Processing unwanted medication from wards and departments • Maintaining adequate supplies of Patient Information Leaflets and other related information leaflets and charts • Undertaking regular expiry date checks of ward stocks
Pharmacy Staff undertaking medication supplies from a dispensary	• *Supplying stocks of medicines to wards and departments and for dispensing medicines for use by individual patients.* • *Procure medicines* • *Supply and/or dispense ready to administer medicines* • *Provide medicines for discharge/leave* • *Advise on the safe, effective and economic use of medicines as agreed* • *Ensure safe and secure transport of medicines*

4 Medicines framework

4.1 Safe and secure handling of medicines

4.1.1 Prescribing and initiation of treatment

4.1.1.1 Consent to treatment

- Before providing care or treatment a health professional should be satisfied that the patient has given their valid consent
- For patients detained under the Mental Health Act 1983, they must only receive medicines that are duly authorised and administered in line with the Mental Health Act 1983 Code of Practice.
- When treating patients who may lack capacity, health professionals should give careful consideration the Mental Capacity Act (MCA) 2005 by completing the MCA1 and MCA2 forms as appropriate
- Capacity to consent continues to be applicable for those patients subject to Mental Health Act 1983.
- Consideration needs to be given to the timely completion of consent to treatment forms (T2 and T3)

- See Policy for Consent to Examination or Treatment

Essential reading associated with this section:
- Policy for Consent to Examination or Treatment

4.1.1.2 Initiating pharmacological treatment

- **Prescribing & alternatives to prescribing:** A patient's pharmacological treatment is, after a diagnosis, usually initiated either by a patient specific prescription from a prescriber (registered doctor, registered dentist or other Trust registered prescriber). In some cases a medication may be initiated via a Patient Group Direction (PGD - see section 4.4) or a protocol which has been approved by the Drug and Therapeutics Committee.
- **Allergies and sensitivities** must always be recorded on the patient's clinical records including all drug administration and prescription records - see Medication Safety Series (MSS) MSS 7
- **Prescribing via verbal and faxed orders** can only be used in restricted situations (see Medicines – Prescribing and initiation of treatment)
- **Medication selection**: Only medicines approved for use by the Drugs and Therapeutics Committee can be prescribed to treat mental health conditions TEWV Trustwide Formulary
    - Prescribers should follow approved local and national guidelines to support prescribing decisions. Prescribing outwith these guidelines should follow agreed processes and have a supporting entry in the patients clinical notes, explaining the rationale.
    - The TEWV formulary is titled as the County Durham & Darlington Formulary (the area where it was developed), but is applicable across the trust. This link takes you directly to BNF chapter 4 of the formulary.
- **High risk medicine processes and critical medicines**: A number of medicines have been identified through the National Reporting and Learning System (NRLS), and locally, as being high risk in terms of the potential harms associated with their use. Critical medicines have been identified as those medicines which may cause harm if they are omitted or delayed. Some medications involve a high risk process as well as being a critical medicine. Greater care is required with these medicines - specific advice is contained within Medication Safety Series Documents
- **Recording on Paris:** Standards for prescribing and recording information about prescribed medicines on PARIS must be followed
- **Drug Prescription and Administration Charts:** The requirements for using and writing drug prescription and administration records must be followed. These charts:
    - Provide a permanent record of the patient's treatment with medicines
    - Indicate the patients' sensitivity to medicines
    - Direct and record the administration of the medicines to the patient
    - All prescriptions must be in black ink and written in block letters to facilitate legible faxing and scanning. The administration record lasts for a maximum of 12 weeks for regular medication, after this period treatment must be re-written if it is to be continued. (If there are less than 7 prescriptions for regular medication, these may be rewritten into section 2 of regular medication of the same chart provided the entries in section one are clearly discontinued).
    - A range of TEWV approved charts are available. In addition, local area palliative care charts can be used as clinically appropriate.
- **As required medications standards - see** Standards for use of 'as required' medication which promote safe, effective, and appropriate prescribing and administration of "as required" medication. The standards encourage regular review of "as required" prescriptions and discourage unnecessary routine "as required" prescribing. Specific age

group guides to common frequencies and maximum doses for "as required" medication are available:
    - Children & Young People unless otherwise stated the age range is considered to be 12 – 18 years inclusive.
    - Working age adults
    - Older people
- **Controlled Drugs:** Prescribing controlled drugs must comply with legal requirements - see Controlled Drugs Standard Operating Procedures
- **Prescribing for staff, family and friends is not allowed**
- **Prescribing issues identified:** Any health professional identifying prescribing queries / issues relating to a potentially serious error or risk must be alert the prescriber immediately / as soon as practicable

Essential reading associated with this section:
- Medicines – Prescribing and initiation of treatment
- TEWV Trustwide Formulary
- Patient Group Direction policy
- Medication Safety Series Documents
- Controlled Drugs Standard Operating Procedures

4.1.2 Medicine reconciliation

- The purpose of medicines reconciliation is to reduce medication errors occurring when patients transfer between care settings, particularly at the time of admission.
- The aim of medicines reconciliation is to ensure that the correct medicines are provided to the patient at all transition points between admission and discharge from hospital through a process of checking medicines prescribed against the most recently available lists from reliable sources of prescribing and supply. Procedure for Medicines Reconciliation
- For the majority of admissions the pharmacy team will perform medicines reconciliation within 48 hours of admission. However when this is not possible to ensure patient safety non-pharmacy staff must undertake the medicines reconciliation process.

Essential reading associated with this section:
- Procedure for Medicines Reconciliation

4.1.3 Ordering and receipt of medicines

Medicines – ordering, storage, security, transporting and disposal

- **Procurement** of medicines is managed through the dispensing pharmacies.
- Medicines kept as a **ward stock** will normally be the medicines that are commonly prescribed for the patients of the ward, but may also include medicines that are not regularly used, but timely access is important. Care should be taken to avoid over ordering while still maintaining sufficient stocks.
- **Non-stock medicines** are dispensed for an individual patient and labelled with the patient's name. They should be ordered on the appropriate stationery by a prescriber or through an approved procedure.
- Medicines for **leave and discharge** are supplied for an individual patient who has authorised leave from the ward or who is to be discharged. Only medicines labelled with the patient name and appropriate directions can be given to patients to take home. Ward stock medicines must not be used for this purpose. Supplies for leave and discharge should normally be sent to the ward for issue to patients.

- All medicines must be **delivered** to wards/departments in a secure container.
- The **receipt** of medicines describes the formal activities undertaken when medicines are received by the Trust from any external source or transferred from one location to another within the organisation. Records of receipt must be maintained.
- All medicines received by the Trust for administration to patients (including those brought in by patients - see 4.1.4) must be of a specified quality and suitable for the purpose for which they are intended.
- Processes must be in place which can confirm the suitability of medicines. The ward or department manager must ensure that the environmental and security aspects of transfer conditions and storage locations comply with the guidance.

Essential reading associated with this section:

- Medicines – ordering, storage, security, transporting and disposal

4.1.4 Patients own drugs procedure (PODs)

- PODs are defined as medicines that are the legal property of the patient. They have been prescribed for, or purchased by the patient prior to admission or whilst on leave.
- PODs should be used wherever possible and practical.
- PODs must only be used for the individual patient for whom they have been prescribed.
- Full details of the procedure, including assessment of suitability for use can be found here Patient Own Drugs (PODs): Procedure for use

4.1.4.1 Crisis and Recovery House

- All patients admitted to the Crisis and Recovery House must be able to self-administer their medicines. The full procedure is here Self-administration guidance for Crisis and Recovery House staff

Essential reading associated with this section:

- Patient Own Drugs (PODs): Procedure for use
- Self-administration guidance for Crisis and Recovery House staff

4.1.5 Pharmacy supply and dispensing

- Supply or dispensing of medicines are the activities undertaken in response to formal orders when medicines are issued to the place they will be used or supplied directly to the patient for administration at a later date.
- Dispensing is the supply after manipulation of the medicine. Manipulation may include preparation, reconstitution, repackaging, and labelling.
- Supply or dispensing is the responsibility of the pharmacy department and community pharmacies (for FP10s)
- Medicines may be supplied as ward or department stocks or as items for specific patients.
- The dispensing process requires a consideration of all the factors which may endanger the safety, effectiveness and stability of the preparation plus adherence to legal requirements.
- Standard Operating Procedures (SOPs) will be in place and followed in each dispensary.

Essential reading associated with this section:

- Medicines – ordering, storage, security, transporting and disposal
- Clinical trials involving pharmaceutical products

- Guidance on Unlicensed and Off-Label Use of Medicines

4.1.6 Transport of medicines

- When medicines are moved between locations it is the responsibility of the manager of the dispensing pharmacy or transferring ward or department and the receiving ward or department to ensure that procedures are adhered to (Medicines – ordering, storage, security, transporting and disposal and local SOPs). This ensures that the medicines remain safe and secure during transfer with minimum risks of misappropriation, and that product integrity is maintained.
- It is the responsibility of both the healthcare professionals who are issuing and receiving the medication to ensure that accurate and complete communication of information accompanies the transfer so that patient safety is not compromised and the audit trail is maintained.

Essential reading associated with this section:

- Medicines – ordering, storage, security, transporting and disposal

4.1.7 Storage and security of medicines

- The Chief Pharmacist must be involved at an early stage in any plans to upgrade or build **new medicine storage facilities in healthcare premises** and must approve final plans prior to placing orders for storage systems. Failure to do this may result in the provision of unsafe, inefficient and, potentially, illegal medicine storage solutions. It may also entail costly retro-fits.
- Once medicines are **received** onto the ward or department the Appointed Practitioner in Charge is responsible at all times for ensuring the safekeeping of the medicines which includes both environmental and security aspects.
- All cupboards, closed storage units (i.e. with doors) and fridges in which medicines are stored must be **lockable** and should be locked when not being accessed. Locks for metal cupboards (except patients' drugs cabinets) must comply with BS 3621.
- All medicine cupboard keys are the responsibility of the Appointed Practitioner in Charge. Custody of the medicine cupboard **keys** are the responsibility of the Designated Practitioner in Charge.
- Medicines for Clinical **Emergency** must be readily accessible but securely stored to prevent unauthorised access.
  - There should be appropriate storage and use of **medical gases** as per Medicines – ordering, storage, security, transporting and disposal

Essential reading associated with this section:

- Medicines – ordering, storage, security, transporting and disposal
- Oxygen & other medical gases – administration, prescribing, storage and safety

4.1.7.1 Staff Personal Medication

- All staff requiring access to their own **personal medication** whilst at work must ensure that the medication is:
  - In the original container
  - Clearly labelled with the staff members name
  - Stored in a secure location e.g. staff locker
- To ensure adequate health and safety, to manage risk and to maintain the safety of patients, colleagues and visitors; if a staff member needs to carry medication on their person for urgent use e.g. salbutamol inhaler, GTN Spray, they should discuss this with their line manager and agree appropriate precautions.
- For staff working in Forensic Services:

- Any non-urgent staff medication should be stored in a locker outside of the secure perimeter.
- Any non-urgent but frequent/regular medication e.g. antibiotics should be stored in a staff locker on the ward.
- Any medication which may be required for urgent use should be discussed with the relevant ward manager, a risk assessment undertaken and an appropriate course of action agreed.

4.1.8 Preparation and administration of medicines

- **Instructions to administer:**
  - Medicines are administered to a patient according to the written directions of a prescriber or a patient group direction (PGD).
  - Remote orders may be appropriate in limited circumstances. A detailed process is defined in Medicines – Prescribing and initiation of treatment
- The administration of a number for medicines for the purpose of saving a life is underpinned within schedule 19, Regulation 238 of the Human Medicines Regulations of 2012 which enables them to be administered without a prescription. This practice is supported with the following documents for adrenaline and oxygen.
- Administration may require the calculation and selection of doses and the preparation of injections or mixtures.
- The administration of medicines is an important aspect of the professional practice of registered nurses. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a registered prescriber. It requires thought and the exercise of professional judgement.
- Use an oral/enteral syringe to measure oral liquid medicines if a medicine spoon or graduated medicine pot cannot be used. NEVER use IV/IM syringes to administer oral liquid medicines.
- **Administration advice** – The BNF lists advisory labels for medicines which have specific administration requirements. This advice should be followed for inpatients recognising there may be occasions when a clinical decision is taken not to follow this advice. Further support is available via MSS 8: Administration of medicines in relation to food and other special instructions
- **Self-administration of medicines** in hospital by patients allows them to administer their own medicines with the support and education provided by the multi-disciplinary team (MDT). The process uses this guidance Self-medication by inpatients guidance
- **Medicine administration record charts procedure (MAR charts):** There are some services within the Trust which receive medical and prescribing services from teams outside the Trust but the administration of medicines is the responsibility of Trust staff. To accommodate these situations an agreed process to record administration of medicines that are not prescribed by Trust staff is required. This procedure is followed Medicine Administration Record (MAR) chart - procedure for use
- **Covert administration**
  - Consideration of covert administration requires best interest meetings to be held with people who know and understand the person using the services to decide whether this is in the person's best interest. Covert administration procedure
- **Administration of Subcutaneous Fluids** (Hypodermoclysis) - see Royal Marsden Manual Online (see links and details below)
  - Hypodermoclysis is well recognised and commonly used as an appropriate and effective measure to correct mild to moderate dehydration.
  - It is not suitable for emergency situations or for severe dehydration
  - This procedure must only be carried out by Doctors or qualified nursing staff.

  - This procedure is for inpatients only. Patients should not be admitted from the community for subcutaneous fluids. In this instance, admission to the acute hospital is required.
- Procedure for Prescribing, preparing and administering of **injectable medicines**
  - This procedure is adopted for use on Birch Ward, West Park Hospital
  - IV medications will only be administered to inpatients on the ward between the hours of 9am and 5pm Monday – Friday and no infusions will be commenced that cannot be completed within this time frame.
  - The only staff who will be involved in any part of the prescribing, preparation and administration of IV medications will be the ward RGN and the ward physical health doctor (employed by North Tees and Hartlepool NHS Foundation Trust).
- **Percutaneous Endoscopic Gastrostomy (PEG) Feeding**
  - Medicines are not specifically formulated for enteral administration therefore use via this route requires careful consideration and caution to ensure safety and effectiveness. A pharmacist must always be consulted if there is any doubt about administering a medicine via the enteral route.

Essential reading associated with this section:

- Medicines – Preparation and administration
- Self-medication by inpatients guidance
- Medicine Administration Record (MAR) chart - procedure for use
- Covert administration procedure
- Administration of medicines in relation to food and other special instructions (MSS 8)
- Administration of adrenaline for anaphylaxis (MSS 9)
- Oxygen & other medical gases – administration, prescribing, storage and safety
- Oxygen administration in an emergency (MSS 10)
- Royal Marsden Manual Online (RMMO) of Clinical Nursing Procedures.
  - Access the Administration of Subcutaneous Fluids Procedure on the RMMO http://www.rmmonline.co.uk (using a generic log in: username: Tees and password: Tees) or via the Library and Information Services page by using an Athens password or the Royal Marsden website http://www.rmmonline.co.uk
- Injectable medicines on Birch ward

4.1.9 Disposal of medicines

- Medicines which are no longer required or no longer suitable for their intended use must be removed for safe disposal or re-used in line with legal requirements and environmental regulations.
- Appropriate records should be made to complete the audit trail of the medicine from purchase or receipt to destruction or re-use.

Essential reading associated with this section:

- Medicines – ordering, storage, security, transporting and disposal

4.1.10 Management of patient safety (untoward) occurrences

- The way in which medication alerts are handled is covered in this document. Medicines – management of alerts, recalls, reporting
- Medication errors are identified, recorded, and monitored appropriately reported and investigated according to Incident reporting and serious incident review policy
- Pharmacy maintain systems to ensure that patient safety alerts, rapid response reports and patient safety recommendations disseminated by the NPSA and supplier-led recalls which require action are acted upon within required time-scales
- Trust staff identifying adverse drug reactions (ADRs) should complete a Yellow Card for appropriate and reportable ADRs
- Loss or theft of prescriptions/controlled stationery must be reported

Essential reading associated with this section:

- Medicines – management of alerts, recalls, reporting
- Incident reporting and serious incident review policy
- Managing Staff Involved in Medication Incidents or Errors

4.1.11 Controlled drugs

- Controlled drugs must be handled within the constraints of regulatory requirements. Trust procedures cover all aspects of risk management of controlled drugs which include audit trails for ordering, storing, prescribing, recording, supplying, administration and destruction.
- The Accountable Officer for CDs has overall responsibility for all aspects of the safe and secure management of CDs within the organisation. This appointment is a statutory requirement as identified by the Controlled Drugs (Supervision and Management of Use) Regulations 2006. The Accountable Officer for TEWV is: Christopher Williams, Chief Pharmacist (Tel: 07771 552084 christopher.williams@nhs.net)
- Any incident involving a CD must be reported immediately to the Accountable Officer (AO). In most instances the completion of a Datix report will meet this requirement and ensure the CD AO is notified, however, any significant unaccounted for loss of CDs should be escalated by a direct phone call or email to the CD AO.
- In the absence of the CD AO, Richard Morris (Deputy Chief Pharmacist) is the deputy AO.

Management of Substance Misuse on Trust Premises

- The following Policy & Procedure should be followed
- The Trust's primary aim is to prevent/minimise the use of substance misuse on Trust premises. Posters will be displayed in all clinical areas outlining the Trust's adopted Zero Tolerance policy on the use/possession/dealing of substances and the repercussions of those individuals who disregard the advice given on the notices.
- Patients admitted to hospital for treatment or a substance misuse problem should have a written agreement or contract as part of their care plan. This should include the checks to be made within treatment e.g. breathalyser or urine samples and the steps to be taken if there is continuing substance use.

Essential reading associated with this section:

- Controlled Drugs Standard Operating Procedures
- Managing Substance Misuse on Trust Premises
  - Policy
  - Procedure

4.1.12 Retention of records

- Pharmaceutical records must be retained for the **minimum** period depending on the record type. These retention periods are defined in Medicines - Retention of Records

Essential reading associated with this section:
Medicines - Retention of Records

4.1.13 Code of practice for working with the pharmaceutical industry

- Any proposed arrangement complies with all relevant national and local ethical standards, policies and guidance relating to business conduct and complies at all times with their professional code of conduct.
- Relationships with commercial organisations should be fully declared, transparent and publically disclosed.
- Any formal agreement must clearly indicate the commitment and obligations of both parties and the anticipated outcomes.
- The interests of patients must be paramount at all times. All decisions and actions that are of a clinical nature must be made and managed by the NHS independently of any input from the collaborating pharmaceutical company.

Essential reading associated with this section:
- Conflicts of Interest Policy
- Medicines - Code of practice for working with the pharmaceutical industry

4.1.14 Access to medicines and pharmacy services outside of normal working hours

- Outside of normal working hours, the Trust makes provision so that medicines or pharmacy services can be accessed if needed.

Essential reading associated with this section:
- Medicines – Access to medicines and pharmacy services outside working hours

4.1.15 Compliance aids

- Before there is any agreement to provide medicines in a compliance aid a full documented assessment of compliance problems should take place by a member of the Trust Pharmacy Service.

Essential reading associated with this section:
- Medicines – compliance aids

4.1.16 Clinical trials involving pharmaceutical products

- The Trust has strict procedures to assure legal and indemnity issues are complied with when supplying clinical trial materials to patients.

Essential reading associated with this section:
- Medicines - clinical trials involving pharmaceutical products

4.2 Clinical procedures

4.2.1 Rapid tranquilisation

- Severe behavioural disturbances will sometimes occur despite all attempts to prevent them. It may become necessary to use pharmacological interventions, alongside physical restraint, to maintain the safety and physical health of an individual.
- The administration of medicines under restraint to maintain safety is Rapid Tranquillisation (RT).
- Ensure safe and consistent age appropriate prescribing in accordance with national guidance and current research evidence
- Ensure monitoring the effect of medicines administered and action when necessary if there is a change in condition, including management of side effects and adverse reactions.

Essential reading associated with this section:

- Rapid tranquillisation (RT) policy

4.2.2 Taser Electrical Incapacitation Device post exposure aftercare guidance

Electrical Incapacitation Devices (EID) such as Taser are single or multiple shot weapons designed to temporarily incapacitate a subject through the use of an electrical current, which temporarily interferes with the body's neuromuscular system. The decision to deploy an EID will always be made by a trained police officer following a risk assessment made by them of the situation.

There is an increased risk of adverse responses where:

- a person has been taking drugs or medicines, including alcohol;
- they have a pre-existing medical condition such as asthma, diabetes, epilepsy, cardiovascular disease;
- they are over-aroused, displaying extreme irrational and violent behaviour towards others.

Essential reading associated with this section:

- Taser Electrical Incapacitation Device post exposure aftercare guidance

4.3 Non-medical prescribing

- Guidance (below) is available on both becoming a non-medical prescriber and on good practice for independent and supplementary prescribers and their medical prescriber (supervisor)
- The selection of appropriate healthcare professionals to train will be based upon local service and patient needs. All individuals selected for prescribing training must have the opportunity to prescribe in the post they will occupy on completion of their training.
- NMP practice will take place within a clinical governance framework and individuals are aware of their legal and professional responsibilities and boundaries

Essential reading associated with this section:

- Non-Medical Prescribers (NMPs) Policy and Procedure to Practice
- Non-Medical Prescribers (NMPs): Procedure to access training

4.4 Patient group directions (PGDs)

- It is the responsibility of the Appointed Practitioner in Charge of each ward/department to ensure that if medicines are administered without a patient specific prescription then a valid and current PGD is available to guide practitioners and that the person administering the medicine has undertaken the Trust training for the PGD being utilised.
- All aspects of PGD managements are covered in the PGD policy

Essential reading associated with this section:

- Medicines – compliance aids

4.5 Homely remedies

- Some medicines do not need a prescription to be supplied. These medicines are defined as P and GSL (Pharmacy Only and General Sales List). Within the trust, these types of medicines may be administered under agreed homely remedy protocols / procedures.
- An agreed protocol / procedure, approved by the Drug & Therapeutics Committee must be in place for these medicines to be administered without a prescription.

4.6 Prescribing guidelines

4.6.1 Managed entry of new drugs

New drugs process

- As part of an effective medicines optimisation approach, the Trust has a process for the introduction of new drugs.
- New drugs not evaluated by NICE, the Regional Medicines Optimisation Committee (RMOC) or by the Northern Therapeutic Advisory Group (NTAG) will require an application. The full process is described in this flow chart which contains the application form.
- All new drug applications will be sent to other stakeholders for comment (other TEWV Specialty CDs, CCG Prescribing Leads and Acute Trusts).
- Recommendations from the evaluation group will be taken to the Drug and Therapeutics Committee for approval and implementation.
- Adoption of decisions by all local organisations reduces post-code prescribing and inequalities in access to medication.

Essential reading associated with this section:

- New drugs - Application process for TEWV

4.6.2 Mental Health prescribing guidance

The aim of these guidelines is to encourage safe and efficient prescribing by advising the best evidence based treatments.

Essential reading associated with this section:

- **Anxiety:**
  - Anxiety Medication Pathway for Adults
- **Attention Deficit Hyperactivity Disorder (ADHD):**
  - ADHD prescribing guidelines

- Atomoxetine shared care guidelines
- Lisdexamfetamine shared care guidelines
- Methylphenidate shared care guidelines

- **Bipolar disorder:**
  - **Lithium -** Guidelines on Safe Lithium Prescribing and Shared Care

- **Dementia:**
  - Dementia Care Pathway: Guidance for prescribing acetylcholinesterase inhibitors and memantine in Alzheimer's disease
  - Summary of Pharmacological Treatment Options for Behavioural and Psychological Symptoms of Dementia

- **Depression:**
  - Algorithm for the pharmacological management of depression in children and young people
  - Depression Pathway Medication Algorithm
  - Handy Hints When Prescribing Antidepressants
  - Citalopram & Escitalopram dose reduction and ECG algorithm
  - Antidepressant deprescribing guidelines: Dosulepin

- **Epilepsy:**
  - Buccolam carer information sheet

- **Psychosis:**
  - **Antipsychotics Long Acting Injections (LAIs)**:
    - North of England Guidance on the Use of Antipsychotic LAIs
    - Olanzapine - process for restricted use (approved in Forensics only)
  - **Clozapine**:
    - MSS 4: Clozapine - this document provides an essential overview of clozapine use within TEWV
    - Initiation checklists:
      - In-patient
      - Community
    - Admission checklist
    - Discharge checklist
    - Clozapine and the role of therapeutic drug monitoring (plasma levels)
    - Standard Process Descriptions associated with the supply and monitoring of clozapine
    - GP information sheet on clozapine
    - Clozapine initiation GP leaflet
    - Smoking - the impact of smoking is discussed in appendix 1 of guidance on the use of stop smoking products
    - Unlicensed Intramuscular Clozapine - restricted application process
  - **High Dose Antipsychotics (HDAT)** - guidance on the use of HDAT
    - POMH Antipsychotic dosage ready reckoner
  - **Hyperprolactinaemia** - management guidance associated with antipsychotic use
  - Long Acting Injectable Antipsychotics - North of England guidance
  - **Quetiapine -** guidance on the restricted use of the XL formulation
  - Promazine deprescribing guidelines

- **Sleep Disorders:**
  - Guidance on Safe Prescribing of Melatonin for Sleep Disorders in Children, Young People and Adults

- **Substance Misuse:**
  - Prescribing METHADONE for patients with opiate dependence in Psychiatric or Medical Wards

- **Eating Disorders:**
  - Guidance on the use of atypical antipsychotics as an adjunct to the treatment of anorexia nervosa in adults and young people

4.6.3 Guidance for safe transfer of prescribing

- The majority of medicines prescribed to treat mental health illnesses are covered by NICE guidance. Where prescribing follows NICE recommendations it is expected that prescribing responsibilities can be transferred from secondary to primary care services once patients are stabilised on treatment. This allows secondary care services to concentrate on the provision of specialist support and increases access to services. It also offers a much more convenient system for patients obtaining their medicines and allows primary care to provide comprehensive management of all of a patient's medication.
- An underlying principle of this guidance is that prescribing and monitoring responsibilities must be clearly defined to ensure safe transfer of prescribing. Advice is available from the General Medical Council (GMC) on shared care prescribing.
- The full process for the safe transfer of prescribing, including the requirements of individual drugs can be found here - Guidance for safe transfer of prescribing
- A quick reference guide for the formulary & safe transfer of prescribing aimed at TEWV prescribers is here. Localised versions for GPs are here (CDD, Tees, Hamb & Rich) and here (York, Scarborough, Harrogate)

Essential reading associated with this section:

- Guidance for safe transfer of prescribing

4.6.4 Psychotropic medication monitoring guidance

- The trust's medication monitoring guidance should be followed to ensure that appropriate patient safety checks are in place when medication is initiated and maintained. The guidance only covers mental health medication. For monitoring of physical health medication, the prescriber should refer to local primary care guidelines, the summary of product characteristics or the British National Formulary.
  - The guidance does not replace clinical judgement. Further tests may be necessary on an individual patient basis. TEWV clinicians should state the rationale for additional tests if requesting from primary care.
  - This guide is intended to be used in conjunction with the TEWV Safe Transfer of Prescribing Guidance and all other TEWV clinical guidelines
- **Antipsychotic monitoring:** additionally the Lester tool provides a framework for screening and intervening when monitoring antipsychotics

Essential reading associated with this section:

- Psychotropic medication monitoring guidance
- Guidance for safe transfer of prescribing

4.6.5 Guidance on the use of High Dose Antipsychotic Treatment

- If high doses are to be used this should only be after evidence based strategies have failed and as a carefully monitored therapeutic trial.

- The decision should be taken explicitly by a level ST4 doctor or above with membership of the Royal College of Psychiatrists and should involve completion of an individual risk/benefit assessment.
- The wider clinical team should be consulted as well as the patient, along with a patient advocate if available and if the patient wishes.
- The decision should be documented in the case notes, including the risks and benefits of the strategy, the aims and when and how the outcome will be assessed.

Essential reading associated with this section:

- Guidance on the use of HDAT

4.6.6 Safe Lithium Therapy and Shared Care Guidelines

- Lithium should be initiated in secondary mental health services
- The patient booklet, alert card and record book (or smartphone app) developed by the NPSA will be made available to all patients on lithium and their use supported by healthcare professionals involved in providing care
- Patients prescribed lithium should receive supplies from secondary mental health services until a shared care arrangement is agreed with their GP. This includes patients discharged from inpatient settings who have been newly initiated on lithium
- A patient's clinical condition must be stabilised before requesting shared care. Once the patient is stabilised on lithium they should be considered for shared care between mental health services and the GP. This will normally occur following the first 3 month monitoring check
- Prescribing and monitoring tasks for patients prescribed lithium must stay together. Prior to issuing a prescription prescribers must check that blood tests are monitored regularly and that it is safe to issue a prescription.
- Regular checks on lithium levels, renal function and thyroid function are essential for safe prescribing.

Essential reading associated with this section:

- Guidelines on Safe Lithium Prescribing and Shared Care

4.6.7 Clozapine treatment guidance for psychosis:

- Initiation of clozapine is restricted to consultant psychiatrists registered with the CPMS.
- Clozapine titration can be safely done in the community
- Always consider physical health state, patient adherence with oral medication and blood tests, ability to see patient every day during the early titration phase, support for patient to attend team base or with collection/delivery of medicines, team resources and client preference.
- If you have any concerns with regard to the above consider using a crisis bed or admit to an in-patient area.
- GPs should be aware of clozapine side effects so that physical health problems can be appropriately managed, cardiovascular and metabolic risk factors reduced and patient safety improved.
- GPs must be made aware of potentially fatal side effects associated with clozapine

Essential reading associated with this section:

- MSS 4: Clozapine - this document provides an essential overview of clozapine use within TEWV
- Initiation checklists:
  - In-patient

  - Community
- Admission checklist
- Discharge checklist
- Clozapine and the role of therapeutic drug monitoring (plasma levels)
- Standard Process Descriptions associated with the supply and monitoring of clozapine
- GP information sheet on clozapine
- Clozapine initiation GP leaflet
- Smoking - the impact of smoking is discussed in appendix 1 of guidance on the use of stop smoking products
- Unlicensed Intramuscular Clozapine - restricted application process

4.6.8 Stop smoking product guidance

- A framework for prescribing stop smoking products for inpatients suffering acute nicotine withdrawal but who do not intend to stop smoking or inpatients suffering acute nicotine withdrawal and who are motivated to stop smoking is available here - Guidance on the use of stop smoking products
- The process for administering and supplying Nicotine Replacement Therapy as a homely (see section 4.5) remedy is covered in appendix 2 of the guidance

Essential reading associated with this section:

- Guidance on the use of stop smoking products

4.6.9 Unlicensed and off-label use of medicines

- These guidelines provide a framework for the prescribing of medicines which do not have a marketing authorisation or are being used outside the terms of the marketing authorisation
- The vast majority of medicinal products used within the trust do have the appropriate marketing authorisation.
- However there are occasions when the treatment of a patient requires:
  - A drug that does not have a marketing authorisation (unlicensed medicine)
  - A drug which has a marketing authorisation but for a condition, at a dose, via a route or for an age that is not listed in the Summary of Product Characteristics for that drug (off-label use)
  - The formulation of a medicine needs to be altered to enable administration via an enteral route (off-label use)
- The choice of treatment requires partnership between patients and healthcare professionals and informed consent should be obtained wherever possible before prescribing any medicines. Patients should be informed of identifiable risks and details of information given should be recorded. A patient information leaflet about unlicensed and off-label use is available to support discussions with patients and carers.

Essential reading associated with this section:

- Guidelines for Unlicensed and Off-Label Use of Medicines

4.6.10 Physical Health Prescribing

4.6.10.1 Antibiotic Prescribing

- Antibiotic resistance is linked to the extent and the way in which antibiotics are used. Inappropriate use of antibiotics is the main driver of antibiotic resistance.

- The aim of this procedure is to:
    - promote prudent prescribing and antimicrobial stewardship to improve patient care
    - minimise the emergence of bacterial resistance in the community for the future

Essential reading associated with this section:

- Antibiotic Prescribing Procedure

4.6.11 Treatment of other physical health conditions

- Healthcare professionals should follow best practice guidelines, primarily those developed by NICE. TEWV have developed supportive guidelines in some commonly seen conditions. These are detailed below.

Essential reading associated with this section:

- **Cardiovascular Risk:**
    - Cardiovascular risk guidelines
- **Chronic Obstructive Pulmonary Disease (COPD):**
    - COPD guideline
- **Diabetes:**
    - Diabetes Management Guideline for Adults and Children
- **Pain:**
    - Pain Management and Assessment Overarching Guideline
        - Pain Management (Non-Cancer) Algorithm for Adult Mental Health and Learning Disability Services
        - Pain Management Algorithm - Acute Pain Post Falls
        - Pain Management Algorithm for Children and Young Peoples Services
        - Chronic Pain Management Algorithm for Mental Health Services for Older People

4.6.12 Herbal Medicines, Essential oils and complementary medicines

- Only those **complementary therapies** which are approved by the Drug and Therapeutics Committee are practiced
    - A designated complementary therapist must have obtained a recognised qualification and be registered with an accredited body for the therapy.
    - Before any complementary therapy is practised the head of service must ensure the practice is in line with the scope of professional practice and code of conduct of the accreditation body for the therapy.
- A record of the patient's consent must be documented in the patient's care plan. If a patient cannot give consent, it is good practice to tell the family/carer/advocate and document their support.
- The therapist must document within the patient's care plan the therapy practised and an evaluation.

- **Herbal medications / supplements** should not normally be initiated within TEWV. Prescribing of these products should, normally, only be associated with continuing a treatment that the patient wants to continue, has brought in with them and is suitable for

use. All herbal medications/supplements for inpatient use should be stored in the patients' medication locker and prescribed on the drug chart before they can be administered.

- Staff caring for patients in Forensic Services should follow the additional points:
    - If a patient would like to commence the use of herbal medicines/supplements then an individual risk assessment must take place during the next MDT. The assessment should include consideration of patient preference, therapeutic benefit, contra-indications, interactions etc. If the request for herbal medicines/supplements is approved, then the item should be prescribed on the medication chart.
    - Patients will be required to self-fund the elective purchase of herbal medicines/supplements.
    - Herbal medicines/supplements should be purchased whilst the patient is on leave and must fulfil the following criteria on return to Ridgeway:
        - Must be declared and handed to a registered nurse
        - Must be in a sealed, original container
        - Must be accompanied by proof of purchase
    - On receipt of herbal medicines/supplements, the registered nurse should:
        - Ensure the medications fulfil the criteria listed above
        - Add the patient name and date of receipt to a blank label and apply to each individual container
    - Any herbal medicines/supplements which are brought onto Ridgeway without an appropriate risk assessment being undertaken should be confiscated until discussion can take pace in the next scheduled MDT.

5 Definitions

Term	Definition
Administration	Giving a medicine by the introduction into the body orally or by injection or by external application e.g. cream or ointment.
Allied Health Professionals (AHPs)	Professions allied to medicines who are regulated by a professional body e.g. physiotherapists, occupational therapists, dietitians.
Appointed Practitioner in Charge	The senior nursing appointment for the ward or department e.g. ward manager, community nurse or team manager with 24 hour responsibility for that ward, team or department.
Controlled Drug	Any medicine regulated by the Misuse of Drugs Act 1971. This may also include any locally agreed substances that it would be appropriate to monitor.
Controlled Stationery	All stationery, which in the wrong hands, could be used to obtain medicines fraudulently e.g. pharmacy requisition books, Trust prescription forms and FP10 prescription forms.
Designated Practitioner in Charge	The senior nurse on duty for the ward or department who has been identified as the nurse in charge for a particular span of duty.
Designated Practitioner	Any registered nurse who has been identified by the Appointed Practitioner in Charge as competent and appropriate to perform a specific function

Dietitian	A dietitian with a current registration with the Health professions Council
Dispensing	To prepare a clinically appropriate medicine for a patient for self-administration or administration by another. The act of dispensing includes supply and also encompasses a number of other cognitive and practical functions which are usually performed under the supervision of a pharmacist.
Illicit Substance	A substance covered by the Misuse of Drugs Act or other legislation, which is not lawfully held in accordance with the relevant legislation.
Licensed Medicines	Medicines which hold a UK Marketing Authorisation and are being used in accordance with the terms of the marketing authorisation.
Non-Medical Independent Prescribers	Staff who have completed Non Medical Prescribing training and are authorised to prescribe any licensed medicine for any medical condition within their competence and as defined in their approval to practice form
Non-Medical Supplementary Prescribers	Staff who have completed Non Medical Prescribing training and are authorised to prescribe medicines specified within a clinical management plan.
Non Registered Practitioners	Health care assistants and support workers who are not registered or regulated by a professional body.
Patient Group Direction (PGD)	A specific written instruction, authorised by a doctor and a pharmacist, for the supply and/or administration of a named medicine in a specified clinical situation in the absence of a written prescription.
Pharmacist	A pharmacist with a current registration with the General Pharmaceutical Council (GPhC).
Pharmacy Assistant	A member of the pharmacy staff who carries out ward stock top up orders and/or issues original packs of medicines to a ward or department against a list, under the supervision of a pharmacy technician and/or pharmacist.
Pharmacy Technician	A Medical Technical officer having achieved an NVQ3 qualification in Pharmacy with BTEC underpinning knowledge in pharmaceutical sciences or equivalent with a current registration with the General Pharmaceutical Council (GPhC). Pharmacy Technicians work under the supervision of a registered Pharmacist.
Senior Pharmacy Technician	A Pharmacy Technician with a current registration with the General Pharmaceutical Council (GPhC) who has successfully undergone further training to undertake additional specified medicines management duties at ward/department level.
Practitioners in Training	Student nurses
Prescribers	Doctors and suitably qualified nurses, pharmacists and other

	designated healthcare professionals.
Supply	To supply a medicine to a ward or patient/carer for administration
Supplementary Prescribers	Nurses, pharmacists and other designated healthcare professionals who have completed Non Medical Prescribing training and are authorised to prescribe within the scope of a clinical management plan agreed with the patient and the doctor who has clinical responsibility for the patient.
Trust Pharmacy Staff	Pharmacists, Pharmacy Technicians and Pharmacy Assistants employed by the Trust and working within the Pharmacy Service providing medicine related advice and support.

6 Related documents

All related documents are linked, in the relevant sections, throughout this framework.

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- Pharmacy will be responsible for monitoring and reviewing this policy and its associated documents on behalf of the Drug & Therapeutics Committee

7.1 Training needs analysis

Training needs are also identified in individual procedures

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered Nurses	Medicines management - face to face	1 day	3 yearly
Registered Nurses	Face to face medication assessment	2 hours	Best practice annual though minimum 3 yearly
Registered Nurses	Injections Awareness eLearning	1 Hour	3 yearly
Registered Nurses	Controlled drugs	2 hours	3 Yearly

	eLearning		
Registered Nurses	PGD training (Crisis teams)	Initial session face to face then 3 yearly eLearning module	3 yearly
Registered Nurses	Drug calculations eLearning	2 hours	As and when: required for NMP applicants and may be used for appraisal or action plans
Registered Nurses (using PGDs)	PGD awareness eLearning	1 hour	Annually for flu fighters and as and when for appraisal or action plans
Registered Nurses	Rapid Tranquilisation eLearning	2 hours	3 Yearly
HCA	Rapid Tranquilisation eLearning	1 hour	3 yearly
Medics	Rapid Tranquilisation eLearning	2 hours	3 yearly
HCA	Witness to Controlled drugs	Half day initially with observed practical assessment then eLearning of 2 hours	2 Yearly currently though going to 3 when new training is implemented.
HCA	Safe and secure Handling of medication eLearning	1 hour	One off

8 How the implementation of this policy will be monitored

Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).**
1	Medicines Management Assessments - 10 key medicines management standards for in-patient units	Monthly (or less often if achieved) / ward visit / Chief Pharmacist via Pharmacy Technicians	Locality Quality Assurance Group

2	Clinical Pharmacy Audit Programme - identified priority areas will be chosen on a 1-2 yearly basis	Deputy Chief Pharmacist (Governance)	Clinical Pharmacy Audit Sub-Group reporting to Clinical Effectiveness Group
3	As identified in the procedures sitting under this framework	Identified in procedures	Identified in procedures

9 References

Underpinning legislation, information and guidance:

Relevant evidence-based guidance and alerts about medicines management and good practice published by appropriate expert and professional bodies, including:

National Institute for Health and Care Excellence

Medicines and Healthcare products Regulatory Agency

Department of Health and Social Care

NHS Improvement & NHS England

Royal Pharmaceutical Society (RPS)

Medical and other clinical royal colleges, faculties and professional associations

- The safe and secure handling of medicines: a team approach (RPSGB, 2005)
- Research governance framework for health and social care: Second edition (DH, 2005)
- CQC – Safer management of controlled drugs; annual reports
- Medicines, Ethics and Practice (RPS)
- Professional Standards for Hospital Pharmacy Services (RPS)
- NHS Protect Medicines security self-assessment tool

10 Document control

Date of approval:	26 September 2019	
Next review date:	1st May 2021	
This document replaces:	Version 7.1	
Lead:	Name	Title
	Christopher Williams	Chief Pharmacist
Members of working party:	Name	Title
	Pharmacy Leadership Team	Pharmacists, Technicians & Medicines Management Nurse
This document has been agreed and accepted by: (Director)	Name	Title
	Ruth Hill	Chief Operating Officer
This document was approved by:	Name of committee/group	Date
	Drug and Therapeutics Committee	26th September 2019
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	
An equality analysis was completed on this document on:	15th March 2018	

Change record

Version	Date	Amendment details	Status
6.1	February 2015	Added Self administration guidance for crisis house and recovery staff at section 3.1.4	Superseded
6.2	September 2015	Updated hyperlink to Influenza vaccine to PGD 16-7 at 3.4.5	Superseded
7	15/3/18	Format changed from tabular to bullet points Essential reading guides added throughout Some details removed from within this framework, but are maintained in the procedures noted beneath this framework Sections 4.1.71., 4.5, 4.6.4, 4.6.11 & 4.6.12 are new to this document but previously agreed through D&T	Superseded
7.1	22/11/18	Page 9 – line added to enable the use of palliative care charts from other organisations	Superseded

7.2	26/9/19 (for publishing on 4/11/19)	Minor amendments: Added Nursing Associates to roles & responsibilities (page 6) Removal of reference to contracted pharmacies (pages 8, 11 & 24)	Draft

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Pharmacy					
Name of responsible person and job title	Christopher Williams, Chief Pharmacist					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Drug & Therapeutics Committee Pharmacy Leadership Team					
Policy (document/service) name	Medicines Overarching Framework					
Is the area being assessed a…	Policy/Strategy	x	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
Geographical area covered	The area covered by TEWV					
Aims and objectives	To provide a framework for medicines use within TEWV					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	1/1/18					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	**15/3/18**					

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay or Julie Barfoot on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Patients, carers, staff, other healthcare professionals					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No
Yes – Please describe anticipated negative impact/s **No** – Please describe any positive impacts/s The document outlines the legal framework and best practice use of medicines which will help to optimise use for all patients.					

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	**X**	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports	• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership
Yes – Please describe the engagement and involvement that has taken place
No – Please describe future plans that you may have to engage and involve people from different groups
No - engagement not expected to be required with this document. It is a revision to that which already exists and encompasses a range of procedures that have been approved and legislation which cannot be amended.

5. As part of this equality analysis have any training needs/service needs been identified?	
Yes	Please describe the identified training needs/service needs below See section 7.1
A training need has been identified for;	

Trust staff	Yes	Service users	No	Contractors or other outside agencies	No

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so	
The completed EA has been signed off by: You the Policy owner/manager: Type name: Christopher Williams	Date: **15/3/18**
Your reporting (line) manager: Type name: David Brown	Date: 15/3/18
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046	