

Medicines – Ordering, storage, transfer, security and disposal

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1 Purpose

Following this procedure will help the Trust to:

- Manage risks with medicines through effective procedures for handling medicines
- Ensure medicines are supplied, transported, transferred, stored and disposed of in a safe, legal and timely way

2 Related documents

This procedure describes what you need to do to implement the Ordering and Receipt of Medicines section of the [Medicines Overarching Framework](#).



The Medicines Overarching Framework defines compliance requirements for safe, secure and appropriate handling of medicines which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ [Medicines – Retention of records](#)
- ✓ [Oxygen & other medical gases – administration, prescribing, storage and safety](#)
- ✓ [Disposal of clinical waste](#)
- ✓ [Controlled Drugs Standard Operating procedures](#)
- ✓ [Depot and Long Acting injections Inpatient Procedure](#)
- ✓ [Depot injections Community Procedure](#)
- ✓ [Patients Own Drugs procedure](#)
- ✓ [Prescribing and initiation of treatment](#)

3 Ordering and receipt of medicines

Controlled stationery describes all stationery which, in the wrong hands, could be used to obtain medicines fraudulently.

Controlled stationery includes; inpatient prescriptions, leave/discharge prescriptions, controlled drug order books, outpatient prescriptions, FP10 prescriptions and pharmacy stock requisition books.

It must be kept in a secure place i.e. locked away in a locked drawer, drug trolley, drug cupboard or filing cabinet with access restricted to designated personnel; nursing staff, doctors, ward clerks and pharmacy staff.

In-patient / leave / discharge / outpatient / day unit prescription pads, ward stock requisition books and controlled drug order books are ordered locally from Pharmacy teams at Lanchester Road Hospital, Roseberry Park Hospital, York or West Park Hospital. FP10 prescription pads are available on inpatient wards for emergency use out of hours.

Pharmacy maintains a log of all controlled stationery issued to wards, teams and medical staff.

All registered nurses must provide a copy of their signature to pharmacy before being able to order controlled drugs; signatures are to be supplied using the registered nurse specimen signatures for pharmacy form – appendix 6. The ward manager is responsible for ensuring the authorised signatories list is up to date. All Doctors and NMP's who order medication including controlled

drugs must provide a specimen signature to Pharmacy. A record of authorised signatures for ordering medicines will be maintained by the Chief Pharmacist.

All records, including those for controlled drugs, requisition books; receipt of medicines must be retained and stored confidentially for a set period of time. The records can then be destroyed according to the Department of Health destruction criteria ([Retention and Disposition of Records Procedure](#) and [Medicines – Retention of records: Section 3](#))

Local procedures may differ between sites

3.1 Patient's own drugs

- PODs should be used wherever possible and practical.
- 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 must only be used for the individual patient for whom they have been prescribed.

3.1.1 Using patient's own drugs (PODs)

PODs can only be administered by Registered Nurses (RNs) if:

- They are deemed appropriate for use (see below) AND
 - prescribed on a prescription and administration record by a trust prescriber OR
 - recorded on a medicine administration record (MAR) chart in services approved to use MAR charts (see MAR charts procedure for use)

For further guidance, please refer to [Patients Own Drugs procedure](#)

Patients own controlled drugs must be stored in the controlled drugs cupboard and the receipt and use recorded in the controlled drugs register. (see [Controlled drugs Standard Operating Procedures](#))

Where PODs are stored in individual medicine cabinets for self-medication it is the responsibility of the Designated Practitioner to ensure that if a patient is moved to a new location all of their medicines move with them. The medication transfer book must be used when medications for self-medication schemes are transferred.

At discharge the Designated Practitioner, pharmacist or pharmacy technician must check the patient's own drugs against the discharge prescription. If the items are no longer required, appropriate advice should be given to this effect and the patient encouraged not to take the medicines home. If there has been a change to treatment or if additional medicines are required, supplies should be dispensed by pharmacy

3.2 Ward stocks

Medicines kept as a ward stock will normally be the medicines that are commonly prescribed for the patients on the ward, but may also include medicines that are not regularly used, but timely access is important. Ward stock lists may differ significantly from one ward to another.

Care should be taken to avoid over ordering while still maintaining sufficient stocks.

Pharmacy assistants or pharmacy technicians are responsible for ordering ward stock supplies.

Stock medicines may be ordered via the pharmacy top-up service by:

- ✓ Generating a stock order sheet signed by a member of the trust pharmacy staff
- ✓ Emailing or handing the order to the pharmacy

3.3 Individually dispensed medicines

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.

If a patient is prescribed a medication that is not a POD or ward stock then the medication must be ordered as an individual supply for that patient. The prescription written must meet all legal requirements and standards for writing a prescription see [prescribing and initiation of treatment](#) procedure. Where agreed, there may be circumstances where the prescription and administration record acts as the legal prescription and the items are ordered against this by nursing or pharmacy staff.

Judgment must be exercised in relation to length of patients stay, the prescribed frequency of medication (e.g. prn) and the cost of medication. Up to 28 days' supply of medication should be ordered.

When all required medication has been ordered on an inpatient prescription any remaining blank lines **MUST** be crossed through.



Under no circumstances should medication be added to a prescription that has already been signed by a prescriber

A self-check of all orders should be carried out at the end of the transcribing process.

The process for ordering medicines via this route differs according to the governance processes agreed with the pharmacy: In York the appropriate stationery to order medication for individual patients must be used. An appropriately accredited pharmacy technician can sign the orders as long as the prescription and administration chart has been clinically screened and signed by a pharmacist.

Across the rest of the Trust, approved pharmacy technicians, pre-reg pharmacists and pharmacists can order medication for individual patients using an inpatient prescription. The written prescription must meet all legal requirements and standards for writing a prescription. The order book should then be given to a doctor / non-medical prescriber to sign and date; if not available it can be handed over to a qualified nurse to obtain a doctors signature and date at the earliest opportunity.

When writing orders, Pharmacy staff will initial and date the top right corner of the prescription (this is for the purpose of identifying the pharmacy staff member who has written the prescription and when)

Completed in-patient prescriptions must be removed from the prescription order book and sent to pharmacy.

If the item is required urgently or it is outside pharmacy normal working hours follow the site specific policy.

If a patient has been transferred from another TEWV ward, all non-stock medication (including non-stock controlled drugs labelled for the named patient) and PODs should be transferred with the patient in a tamper evident bag or box. The medication transfer book must be completed to maintain the medicines audit trail.

Once the patient is discharged from the ward the remaining medicines should be stored in the unwanted medication area of the drugs cupboard on the ward until removed by a member of the pharmacy team. Medicines for patients who regularly receive planned respite care may remain on the ward for future use.

Local procedures, in addition to those defined above, may differ between sites.

3.4 Receipt of medicines

The Appointed Practitioner in Charge is responsible for receipt and storage of all medicines.

All medicines must be delivered to wards/departments in secure, tamper evident, locked containers by a porter or pharmacy driver.

In exceptional circumstances when the Designated Practitioner is unavailable a delivery of medicines may be accepted by another appropriate member of trust staff. When this happens the delivery must be signed for by that member of staff, who then must assume responsibility until the delivery can be handed over to the Designated Practitioner.

The Designated Practitioner must:

- ✓ Check the medicine against the delivery note or ward copy of the requisition/order
- ✓ Sign the note or copy requisition/order and keep it (for 2 years) as a record that the supply was complete
- ✓ Lock the medicines in the medicine cupboard/trolley/locker immediately ensuring the stock is rotated. Medicines that require cold storage must be dealt with immediately. As well as controlled drugs.
- ✓ Report any discrepancies to the pharmacy immediately

3.5 Medicines for leave and discharge



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.

Medicines for leave and discharge are supplied for an individual patient who has authorised leave from the ward or who is to be discharged. They must be obtained in advance by sending a completed leave/discharge prescription to the pharmacy. Leave and discharge prescriptions must state the number of days treatment required.

Only in exceptional circumstances should a patient leave the ward without the medicines they require.

3.6 Collection of leave and discharge medicines from Pharmacy by patients

Supplies for leave and discharge should normally be sent to the ward for issue to patients (see section 3.7). In exceptional circumstances, where there are specific patient related reasons that support improved medicines optimisation and adherence, the patient should be allowed to collect leave or discharge supplies from the pharmacy. This can only be by prior arrangement and agreement with the pharmacy so that pharmacy staff are able to manage the work flow to ensure the patient is not kept waiting and robust arrangements for patient identification are in place.

3.7 Handling discharge /leave prescriptions on the ward/department

It is important that the patient receives adequate information about their medicines prior to discharge. The patient should know the purpose of the medicine, how to take it and for how long it is to be taken. Where needed, a medicines reminder chart, detailing the patient's medication, should be completed. It is the responsibility of the Designated Practitioner who discharges the patient from the hospital to ensure that the patient has received adequate information about their medicines. Where possible medicines for leave or discharge should be shown to the patient, to confirm the patient's understanding of their treatment, prior to leaving the ward.

When a handwritten prescription is used, the duplicate copy of the leave/discharge is to be stored in the patient's paper records. Where an electronic Paris prescription is used, an entry on Paris listing all medications and number of days prescribed is sufficient.

3.8 Handling medicines supplied to community bases for community patients

Receipt of all medicine supplies for community patients should be recorded on delivery, prior to being stored securely in the medicines cupboard.

When issuing a supply of medicines to a community patient an identity check must be made.

A record of all medicine supplies issued must be maintained, this can be recorded on PARIS.

If medication is being delivered to a patient's home, the person delivering the medication must record this on PARIS. See section 5.6 for information on transport of medicines by community based staff.

3.9 Sample medicines

No samples (of medicines or dressings) may be left on wards or departments. Representatives of pharmaceutical companies wishing to leave samples must be referred to the Chief Pharmacist.

3.10 Storage and security of medicines

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 medicines must be stored in separate, lockable cupboards, trolleys or other secure receptacles and locked away when not in use. This includes medicines for self-administration, for discharge or for return to the Pharmacy.

The design and location of all ward or department medicine storage cupboards must be approved by the Chief Pharmacist.

Drug cupboards to be used for internal (for use within the body) and external (for use on the body) medicines should comply with the current British Standard (currently BS2881 1989, -NHS Estates Building Note No.29).

The security and physical storage conditions of medicines on wards and departments will be checked periodically by pharmacy staff who will carry out inspections of medicine stocks with reconciliation where necessary.

The necessity for checking stock balances of medicines, other than controlled drugs, will be determined by the Chief Pharmacist following discussion with the Appointed Practitioner in Charge and appropriate Service Manager.

If there is a suspicion of medicine diversion this should be reported to the Chief Pharmacist who will take appropriate action.

3.11 Storage accommodation

Clinical areas may have some or all of the following medicine storage units:

Controlled drug cupboard – secured to a wall and reserved for the storage of controlled drugs.
 See [Controlled drugs Standard Operating Procedures](#)

Medicine cupboard(s) or drawer(s) for internal medicines - for the storage of tablets, liquid medicines, injections etc.

Medicine Cupboard(s) or drawer(s) for external medicines - for the storage of creams, lotions etc.

Medicine Refrigerator – solely for the storage of medicines. Food or pathological specimens must not be stored in the medicines fridge.

Clean Storage Area - for large volume fluids and feeding products.

Medicine trolley or separate medicine cupboard - for storage of medicines in current use on the medicine administration round. When not being used the medicine trolley must be locked and secured to the wall. The trolley must not be left unattended during the medicine round. If the Designated Practitioner leaves the trolley, it must be locked immediately. In areas using medicine trolleys with individual lockers or medicines cupboard with individual drawers the same principles of security apply.

Medicines for medical emergency - must be readily accessible but securely stored to prevent unauthorised access. These may be held in a tamper evident bag which should not be locked in a cupboard. If used, the emergency drug replacement medication form must be completed and the pharmacy contacted to arrange for replacement. The location of the nearest emergency drug bag and defibrillator must be displayed in the clinic of the ward.

The following recommendations for medicine storage in clinical departments are taken from the Department of Health document 'General design principles 6946:0.1: England'_21 July 2011

The cupboard sizes given apply to a general 24-bed ward. All sizes shown are in mm and represent height x width x depth of the storage cupboard or unit. However, exact requirements should be determined locally.

Category of medicine	Cupboard size	Storage requirements
Controlled drugs	Nominal cupboard size: 550 x 500 x 300	A cupboard within a cupboard is not recommended.
Oral solid medicines	Nominal cupboard size: 600 x 1000 x 300	It should be possible to adjust the position of the shelves within these cupboards to allow for the wide range of product sizes. Physical barriers (dividers) should be used to separate products with similar names
Injectable medicines	Nominal cupboard size: 600 x1000 x 300. Two cupboards needed	
Oral liquid medicines and rectal medicines	Nominal cupboard size: 600 x 500 x 300	
Medicines to take home	Nominal cupboard size: 850 x 500 x 550.	This cupboard will be used for prepared discharge medication, which may be bulky.

From the time of receipt until use or removal from the organisation, all medicines should be kept secure, with access only by authorised personnel. This includes medicines brought in by patients but not required for treatment. The legal requirements related to the category of medicine should be applied.

3.12 Sites for cupboards and trolleys

Cupboards and trolleys must be sited where most convenient for staff and to afford maximum security against unauthorised access. Medicine cupboards must generally be sited in a clean utility room to which the general public does not have access. Cupboards must not be sited where they may be subjected to higher than average humidity or temperature. Room temperatures should ideally be maintained at 25°C or less – see appendix 5.

In areas where testing is carried out, a reagent cabinet must be in place.

3.13 Storage of self-administered medicines

All medicines for self-administration must be kept in an individual patient's medicine cabinet, the medicine trolley or other secure storage. A risk assessment must be carried out before siting individual patient medicine cabinets. Individual arrangements for patients who require having personal control of their medication e.g. inhalers or GTN spray should be agreed with a pharmacist.

See [Self Medication Procedure](#)

3.14 Storage of refrigerated medicines

Heat sensitive medicines requiring storage below room temperature will be marked "Store between 2°C and 8°C, in a refrigerator." They must be stored in a pharmacy approved, locked medicines refrigerator reserved solely for the storage of medicines and not in domestic refrigerators.

The efficacy of these medicines may be reduced if the cold chain is not maintained during transport and storage up to the point of use.

When medicines are delivered to a ward/department those items requiring refrigeration should be checked immediately and placed in the refrigerator.

Refer to the Temperature monitoring of medicine fridges and medicine storage areas procedure (Appendix 5)

3.15 Flammable liquids, gases, aerosols

Contact the local Fire and Safety Officer for advice.

3.16 Medical gases

Medical gases should be stored safely, in an area with clear **signage, be secured and** away from sources of direct heat.

- [Oxygen & other medical gases – administration, prescribing, storage and safety](#)

3.17 Locks and custody and safe-keeping of medicine cupboard keys

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.

A second set of keys should be kept in an appropriate, secure location.

3.17.1 Key for the controlled drugs cupboard

The controlled drug cupboard key must be kept separately from the ward keys [Controlled drugs Standard Operating Procedures](#).

3.17.2 Keys for medicine cupboards, medicine trolleys and refrigerators

The keys for the external medicine cupboard, internal medicine cupboard, medicine trolley and medicine refrigerator must be kept together on one key ring reserved solely for these keys. The keys must be clearly identified.

The keys must be kept on the person of a Designated Practitioner. In the event of no Designated Practitioner being on duty in a ward or department, the keys shall be handed to a Designated Practitioner on a ward or department in the near vicinity. This information must be made known to the staff on both wards/departments.

Keys must not be relinquished to any unauthorised person, i.e. nurses not assigned to the ward/department, medical staff or other personnel (with the exception of pharmacy staff in the course of their duties). When providing the keys to a member of the pharmacy team, the pharmacy staff member must be able to be positively identified or steps put in place to enable the identity to be checked.

At community team bases where a number of Designated Practitioners may require access to the medicine cupboards at different times a secure system must be agreed between the Appointed

Practitioner in Charge and a Pharmacy Technician or Pharmacist to limit access to authorised staff.

3.17.3 Keys to individual patient's medicine cupboards

The master key for individual patients' medicine cupboards must be kept on the ward medicine cupboard key ring at all times and must never be issued to a patient.

Keys that open individual patient medicine cupboards/ lockers must be individually numbered and stored in a locked cupboard on the ward when not in use.

See [Self Medication Procedure](#)

3.18 Loss of a medicine cupboard key

Every effort must be made to find the key or retrieve it from off duty staff. Should access to the medicine cupboard be required before the keys are retrieved the Designated Practitioner in Charge should access the duplicate key. If there is no duplicate key they should arrange for the cupboard to be broken open and a new lock fitted. Medication must then be moved to an appropriate secure and locked location. If out of normal working hours loss of keys should be reported to the Duty Manager.

An incident report on DATIX should be completed.

3.19 Closure of a ward or department

If a ward or department is due to close, the Pharmacy Team must be contacted for advice.

4 Transport of medicines

Staff engaged in the transportation of medicines should carry Trust identification, and have received appropriate Trust training relevant to the role.

The medication transfer book must be used to log all medicines transferred when

- Patients are transferred between wards
- Stock medication is loaned between wards outside of usual pharmacy opening hours

This provides an audit trail for transferred medications.

Once complete the medication transfer book is to be stored confidentially for two years from the date of the last entry and then shredded in a confidential secure way.

Equipment used in the transport of medicines should be designed to ensure the security, integrity and quality of the medicine is not compromised and where appropriate the cold chain is maintained.

Below are the details for a bag and seals to be used for the transportation of medication. They can be ordered by raising an NCI order on Cardea and are as follows

- Versapak Secure Holdall - Product Code CCBX Large (CCBX3): 584 x 406 x 254mm (23w x 16h x 10d")
- Versapak Patented T2 Plain Security Seals Product Code PLAINT2

Transfer of medicines outside the healthcare organisation should always be authorised and receipt acknowledged by the receiving body.

Where intermediate carriers (agents, taxis) are used, recording of collections and deliveries should be in place.

4.1 Transport of medicines from pharmacy

All medicines should be transported in sealed, tamper evident containers.

On arrival on the wards/departments/clinics, a registered nurse must sign for receipt and containers should be placed in a designated area. Once delivered to the ward/department/clinic the responsibility for the security of the medicines rests with the Appointed Practitioner in Charge who will arrange for the contents to be unpacked, checked and put away securely as soon as possible.

In exceptional circumstances when the Designated Practitioner is unavailable a delivery of medicines may be accepted by another appropriate member of trust staff. When this happens the receipt of the delivery must be recorded on the ward by that member of staff, who must assume responsibility until the delivery can be handed over and signed for by the Designated Practitioner. The ward record must detail the date, name and signature of the person receiving the package, the number on the seal and the name and signature of the Designated Practitioner ultimately accepting the delivery.

In community bases, where this is not practical, the following process can happen:

- The medication is to be delivered to the team base in a tamper evident container sealed with a numbered seal; reception staff can sign for the delivery.
- The container should then be placed in a separate quarantine medicine cupboard, which is available for reception staff to access. This cupboard should only be used for the temporary storage of deliveries until the designated practitioner can receive, check and put the order away in the correct medication cupboard.
- Alternatively a risk assessed appropriate process can be agreed locally with the pharmacy team.

4.2 Transport of medicines between health services premises

Medicines accompanying a patient being transferred from one hospital to another may be transported between hospitals with the patient in an ambulance or by authorised hospital transport, or taxi. It is important that medicines are packaged securely and are labelled with the destination.

4.3 Transportation by taxis

Taxis can be used to deliver to Trust wards or units. In addition, in extenuating circumstances, such as adverse weather conditions, hospital contract taxi drivers can deliver medicines to community patients providing a risk assessment has been carried out and documented on PARIS

Items must be collected in secure tamper proof packaging from the pharmacy or a ward or unit as agreed with pharmacy.

A system for recording collections and receipt of deliveries must be in place.

4.4 Transport of medicines to individual patients at home

Medicines may be transported home by patients or their carers following a hospital attendance or on leave/discharge.

In exceptional circumstances, patients or carers who have left the hospital before all their medicines have been dispensed may be requested to return to the hospital later to collect their medicines.

Medicines may be transported to the patient's home (or sometimes to a local Health Centre or Community Pharmacy for subsequent collection) by authorised hospital transport, by post using the recorded delivery service or in extenuating circumstance by hospital contract taxi drivers. It is important that medicines are packaged securely and are labelled with the destination.

4.5 Transport of medicines by relatives or representatives of the patient

Relatives or representatives of the patient may collect medicines from the pharmacy on behalf of a patient provided the pharmacy has received prior notification of their impending arrival by the ward, unit or department.

4.6 Transport of medicines by community based staff

4.6.1 Delivery of medicines to community patients

Community staff (Registered Practitioners, Non Registered Practitioners or Allied Health Professionals), as part of their role in the clinical treatment of patients, may deliver medicines as part of the overall care package.



This aspect of care must be documented in the care plan and the patient must be known to the member of staff delivering the medicines.

An audit trail recording receipt of medicines by community staff for transportation must be maintained.

A Trust identification badge should be worn or carried by all staff carrying medication.

All medicines must be transported in a locked box/case or tamper evident containers such as a locked briefcase or locked box out of sight within the locked boot of a car.

A selection of bags recommended for the transportation of medication has been identified but it is not mandatory that these bags are purchased. They can be ordered by raising an NCI order on Cardea and are as follows:

- Small – Elite Community Nurses Bag SKU: EB136
 - 36 x 26 x 10cm
 - Weight 1.2kg
 - Capacity – 9 litres

- Medium – Community Nursing Bag SKU: EB01.008
 - 35 x 25.5 x 14cm
 - Weight 1.35kg
 - Capacity – 12.5 litres

- Large - Elite Comfort Nursing Bag SKU: EB124
 - 40 x 30 x 13cm
 - Weight 3.35kg
 - Capacity – 15 litres

Medication must be handed to the patient (or the carer if they are known to the team). A record of delivery and receipt of the medication can be recorded on PARIS (which can act as the audit trail). Any refusals to accept delivery must be documented in the patient's record. If medicines cannot be delivered they must be returned to the community base on the same day and stored securely.



Medicines must never be posted through letter boxes or left with a person unknown to the team.

4.6.2 Transporting medicines for administration to community patients

Medicines carried by a Community Practitioner for administration must be prescribed as a specified dose for a named patient by a prescriber.

When carrying medicines for IM administration the lockable box/case supplied by the Trust should contain as a minimum, syringes, needles, disposable gloves, leak proof sharps container, and plasters.

Each medicine to be carried must be accompanied by the written prescription on the relevant medicine card and the dose administered must be recorded.

If medicines cannot be administered they must be returned to the community base on the same day and stored securely.

4.6.3 Removal of medicines from community patients

Whenever possible, patients or carers should be encouraged to return any unwanted medicines to the community pharmacy. Trust staff should not be routinely removing medicines from patient's homes for destruction.

However in the interests of patient and public safety medicines that pose a risk to community patients should be removed if they cannot be returned by the patient or carer. An audit trail of any medicines removed must be maintained by completion of the Community settings - Consent for destruction of patient's own medicines (PODs) form (appendix one). **If a patient or carer does not consent to removal the risk must be escalated to the responsible clinician for action.**

Non Registered Practitioners or Allied Health Professionals should always refer to a Registered Practitioner or prescriber prior to removing any medicines from a patient's home.

Any medicines removed should be taken to the nearest community pharmacy for disposal as soon as possible or by the end of the working day. Medicines removed from a patient's home must not be stock piled at community bases, left in cars or taken home by staff. The community pharmacy staff member should be requested to sign the Community settings - Consent for destruction of patient's own medicines (PODs) form (appendix one) acknowledging receipt of the medicines and the form filed in the patient's notes. This audit trail provides protection for staff when removing medicines from a patient's home.

If staff at a community pharmacy refuses to accept patient returns the medicines should be taken to the nearest Trust premises with medicine storage facilities, appendix one should be completed and a copy kept with the medicines. Pharmacy should be contacted for advice.

If medicines are removed out of normal working hours they should be taken to the nearest trust premises with medicine storage facilities. The medication should be taken to the community pharmacy the next working day, with completion of appendix one.

5 Disposal of medicines

The introduction of the Hazardous Waste Regulations in 2005, The Waste (England and Wales) Regulations 2011 and the review of the legal controls on all aspects of controlled drugs have led to significant changes to the way that medicines are disposed of.

5.1 General principles

Medicines that are no longer to be administered to a patient, for whatever reason, should normally be disposed of via the Trust system for dealing with clinical waste. Medication must be stored in the designated unwanted medication section of the medicines cupboard on the ward/clinic until removed by pharmacy staff.

Medicines must never be disposed with domestic-type waste.

Most medicines are not considered to be hazardous waste but are still subject to controlled disposal. Only cytotoxic/cytostatic medicines waste is considered hazardous and this is subject to additional control (consult pharmacy for full list of hazardous medicines).

Medicine waste for destruction will be secured in designated bins and labelled appropriately. A consignment note for destruction of waste will be completed at the point of waste collection by the contracted waste management company and a copy retained by pharmacy.

Additional controls apply to the disposal of controlled drugs to make them irretrievable from the waste ([Controlled drugs Standard Operating Procedures](#))

Small quantities of medicines prepared for use and not given or part used doses may be disposed of via the ward or department in a sharps container, which will be incinerated (see section 6.3).

Patient details on empty containers should either be obliterated with a black permanent marker or placed in a confidential shredding bin.

5.2 Disposal of controlled drugs

See [Controlled Drugs Standard Operating procedures](#)

5.3 Disposal of part-used injections and medicines prepared and subsequently not given

Once prepared for administration medicines must never be returned to the container from which they were originally taken, nor stored in another container on the ward or department.

Medicines other than cytotoxics/cytostatics should be disposed of in a sharps container along with the syringes, needles and ampoules used during the preparation and administration process.

5.4 Disposal of part-used cytotoxic/cytostatic medicines

Small quantities of cytotoxic/cytostatic medicines (i.e. doses prepared and not administered and unused part-doses etc.), syringes, needles, ampoules may be disposed of in a sharps container specifically reserved and labelled for this type of hazardous waste and disposed of via the waste disposal service. Contact the pharmacy team for advice related to cytotoxic/cytostatic medication.

5.5 Disposal of empty medicine containers

Empty medicine containers should **not** be returned to the pharmacy. The patient's details should be removed from the label prior to disposal of the container.

If any residual liquid medicine remains, the container should be stored in the unwanted medication section of the medicines cupboard on the ward/clinic until removed by pharmacy staff.

5.6 Disposal of suspected defective medicines

Suspected defective medicines and medicines involved in any suspicious or unusual incident must not be destroyed. Follow [management of alerts, recalls and reporting](#) or contact the Pharmacy Team immediately for advice.

5.7 Disposal of patient's own drugs

See [Patients own drugs procedure](#)

See Section 10.7.3 for Controlled drugs belonging to patients (see [Controlled drugs Standard Operating Procedures](#))

In the community setting patients and carers should be advised to return all medicines, including controlled drugs that they no longer require, to a community pharmacy (see section 5.6.3).

5.8 Interpretation of expiry dates

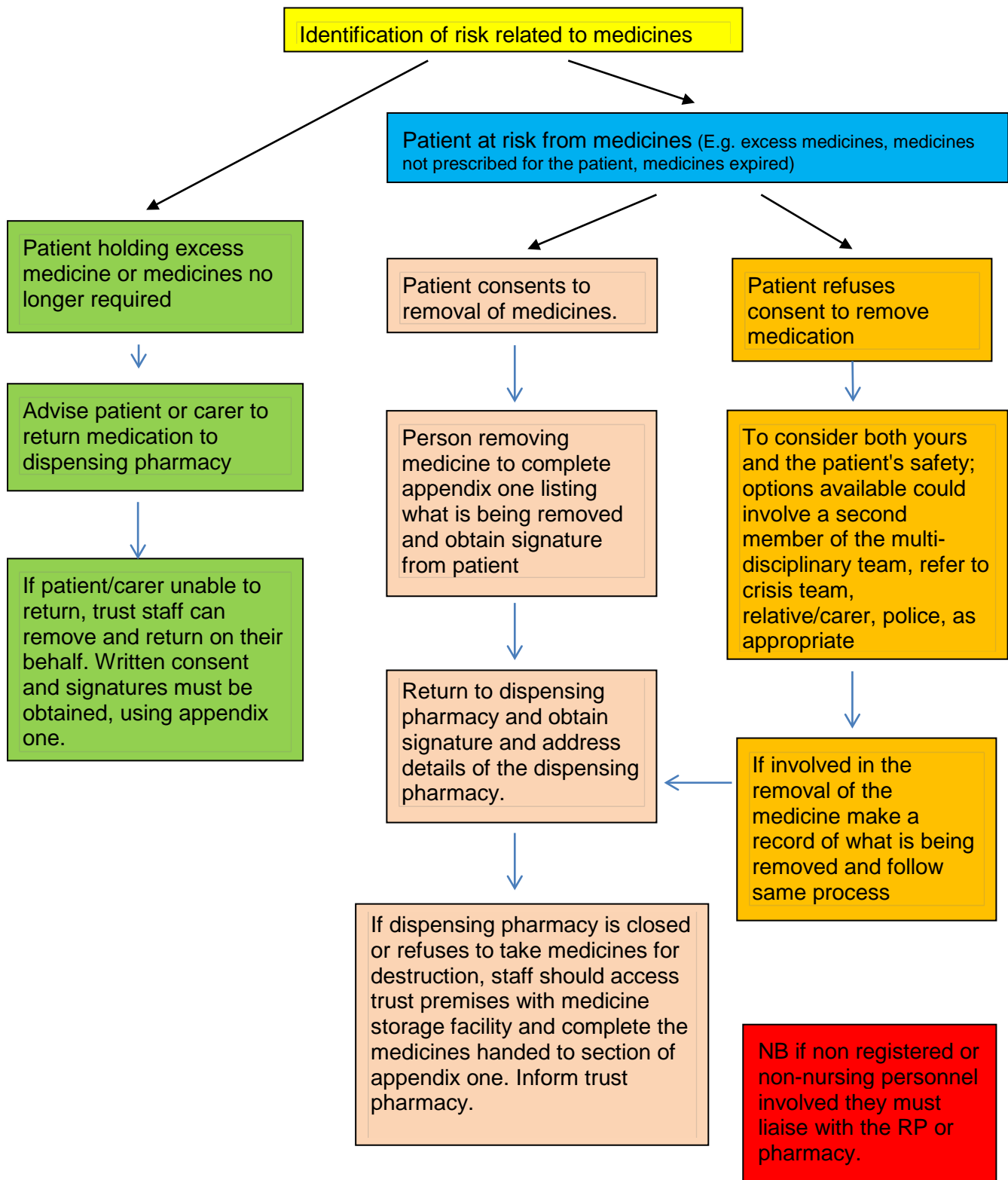
Expression	Interpretation
Use by May 2021	Do not use after 30 April 2021
Use by 20 May 2021	Do not use after 19 May 2021
Use before May 2021	Do not use after 30 April 2021
Use before 20 May 2021	Do not use after 19 May 2021
Expires 31 May 2021	Do not use after 31 May 2021
Expiry date 31 May 2021	Do not use after 31 May 2021
Expires May 2021	Do not use after 31 May 2021

5.9 Pharmacy endorsements on the prescription and administration record

Endorsement in pharmacy comments box	Interpretation
POD	Patients Own Drugs
P	Named patient supply
S	Stock medication

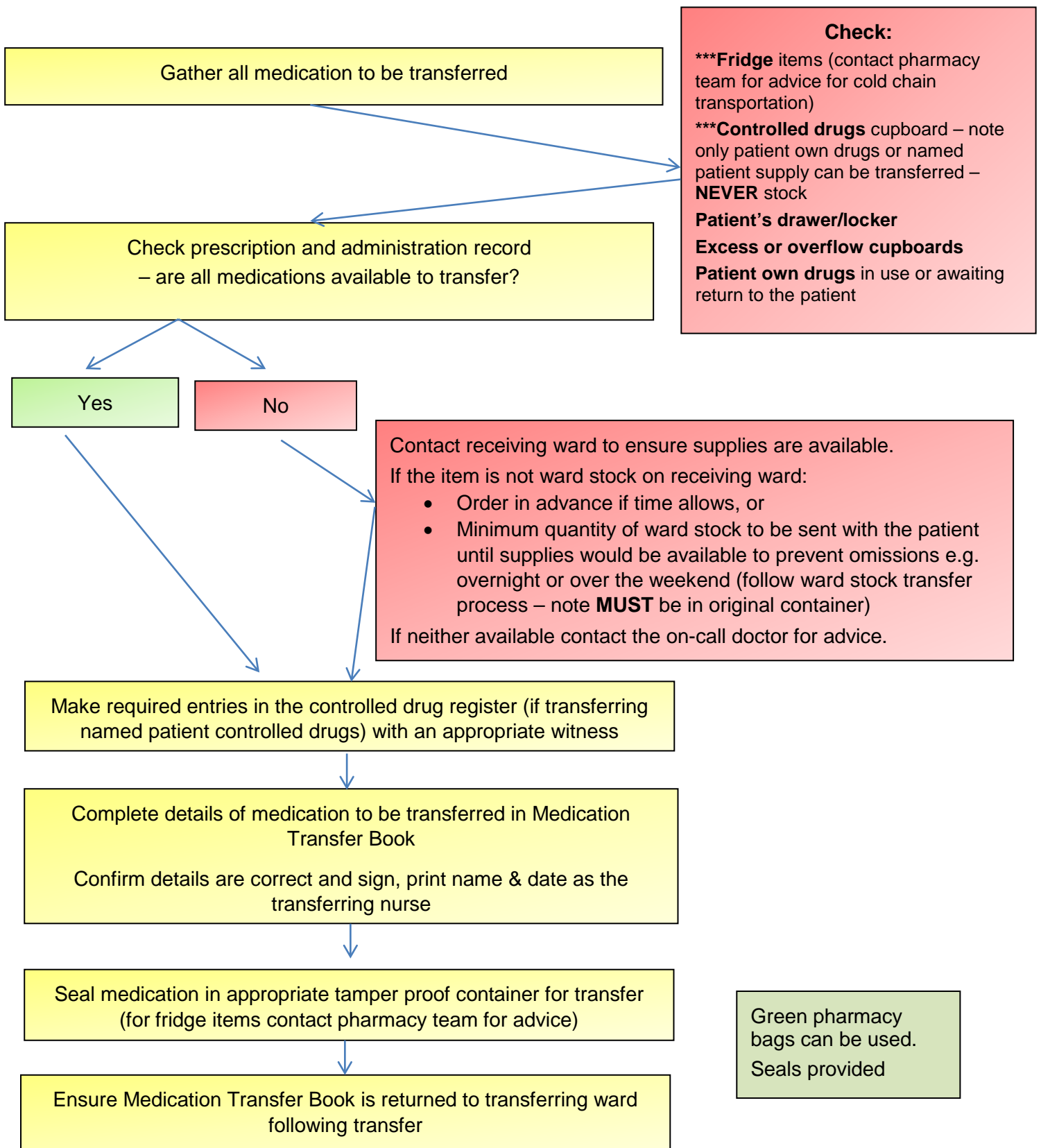
SM	Self medication
OSD	One stop dispensing
CD	Controlled drug medication

7 Appendix 2 – Removal of medicines from a patient’s home



8 Appendix 3a – Transferring medication – when a patient is transferred between care settings

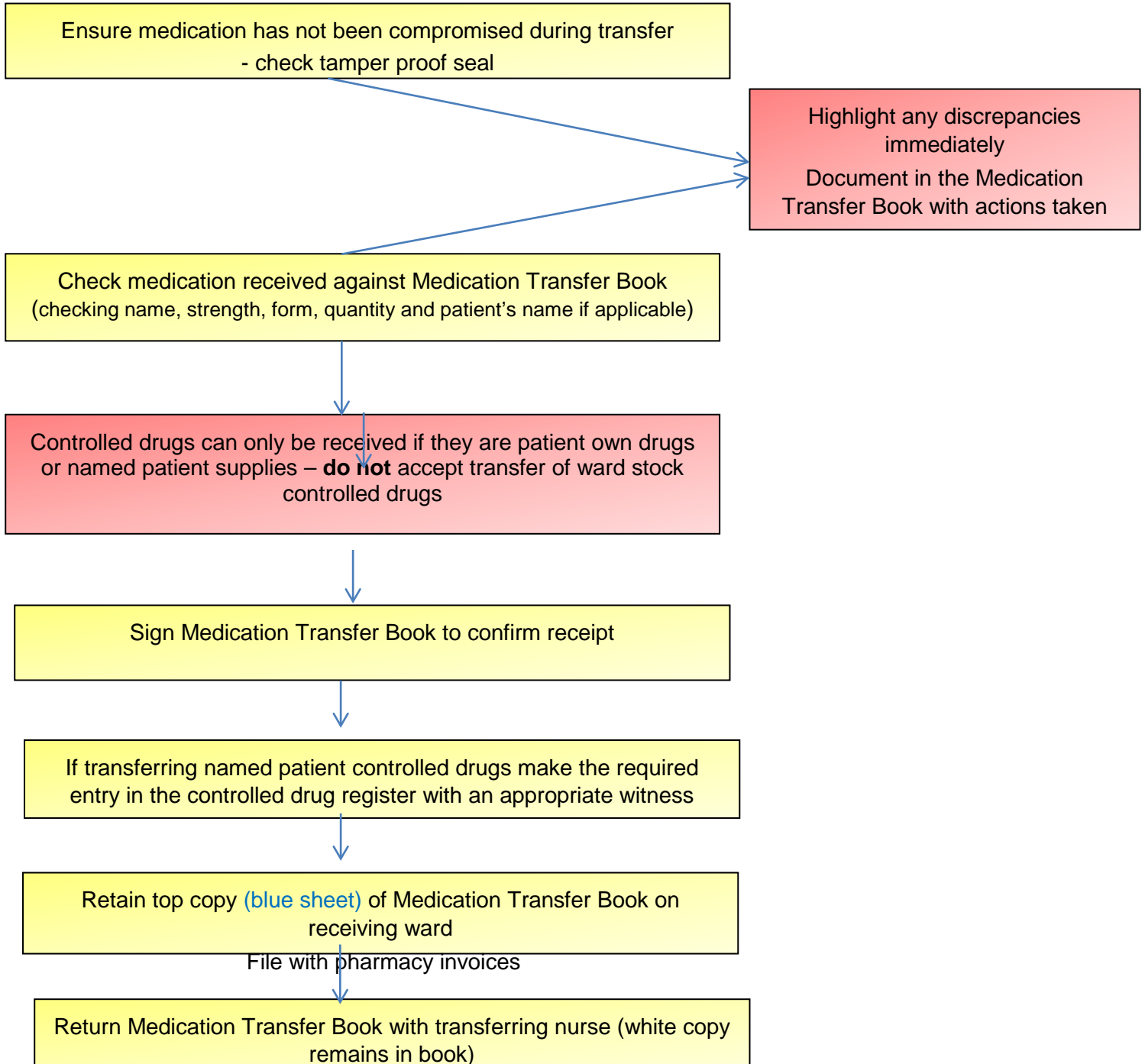
TRANSFERRING WARD:



9 Appendix 3b – Transferring medication – when a patient is transferred between care settings

RECEIVING WARD:

On receipt of medication:

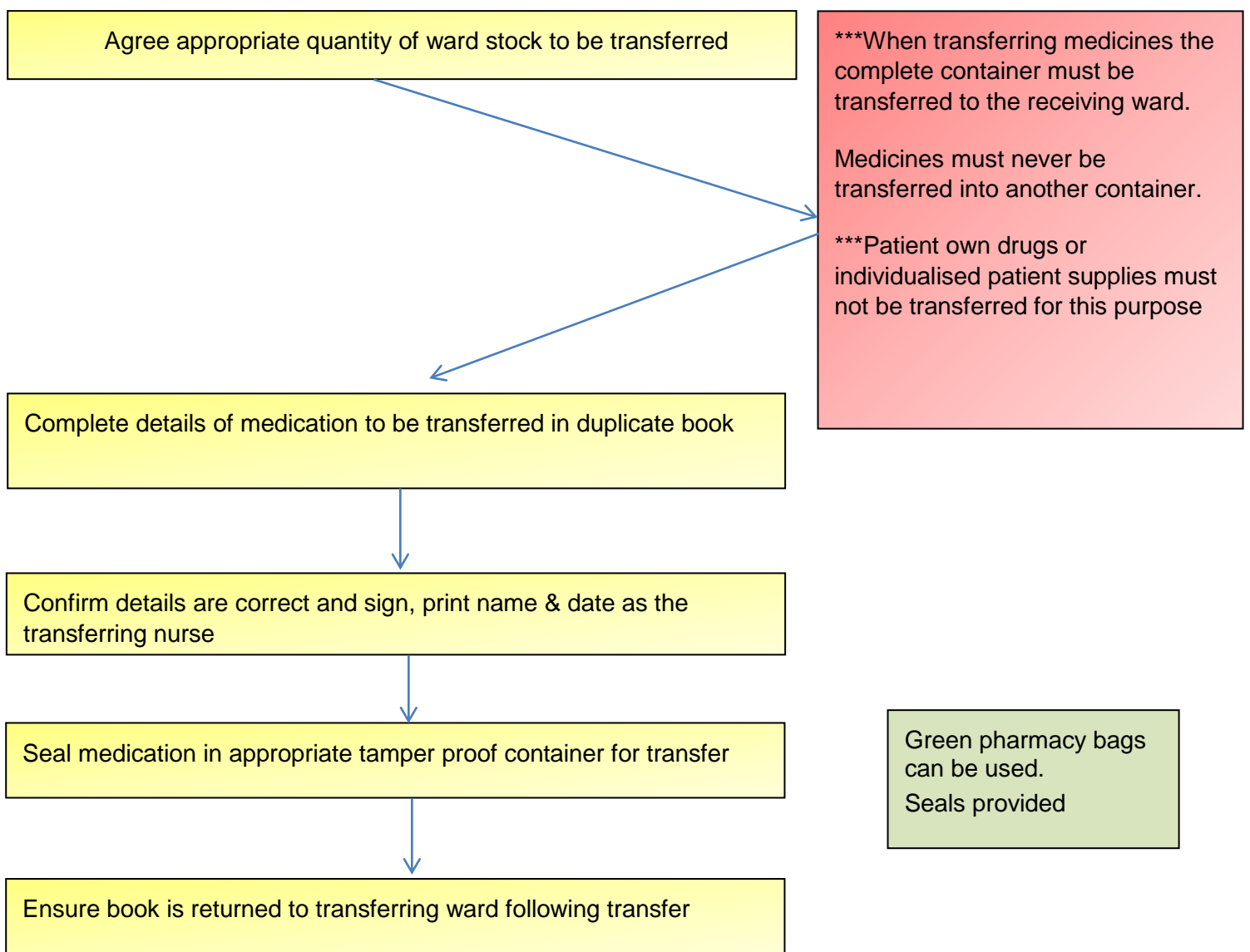


10 Appendix 4 – Transferring ward stock medication

Transferring WARD STOCK Medication (Previously Referred To As Ward Stock Loans)

PLEASE NOTE: Controlled drugs ward stock should **NEVER** be transferred between wards
(Contact Trust pharmacy team/on-call pharmacist if controlled drugs are not available)
Medication transfer (loan) from another ward must only take place when pharmacy is closed

TRANSFERRING WARD:



11 Appendix 5 – Temperature monitoring of medicine fridges and medicine storage areas

Purpose

- To ensure all medicines fridges are maintained within a safe temperature range of between +2°C and 8°C.
- To take appropriate actions for consistent medicine storage room temperatures above 25°C
- To ensure the temperature is monitored and logged on a daily basis and appropriate actions are taken to maintain the integrity of the medicines held within the fridge and the medicine storage area.

Scope

To cover all wards, units and CMHT's who may need to store medication.

Responsibility

The nurse in charge of the ward/unit/CMHT is responsible for ensuring this procedure is followed and may delegate a member(s) of staff to monitor the medicines fridge and room temperatures. The person with responsibility for the management of the ward or department has responsibility for ensuring staff are adequately trained and are able to comply with this procedure.

Process

The current, maximum and minimum temperature of the refrigerator and room must be monitored and recorded **each working day** using a digital calibrated maximum-minimum thermometer. If the unit/ward is closed document this on the appropriate days for both the room and the fridge temperatures.

For the appropriate month, using the combined temperature monitoring sheet for medicines storage areas and medicines fridges located on the front of the fridge, record the following information:

- **The minimum temperature** – use correct procedure depending on thermometer type.
- **The maximum temperature** – use correct procedure depending on thermometer type.
- **The current temperature** – use correct procedure depending on thermometer type.
- After recording the above information **reset** the thermometer using correct procedure for thermometer type.
- Initial the form and return it to the front of the medicines fridge.
- Completed forms must be filed and stored for one year.

At the end of each month it is the responsibility of the nurse in charge of the ward/unit/CMHT to review the monitoring form and sign the bottom of the form

Medicines Fridges

Temperatures falling outside the accepted range

Lec medical model

The alarm will sound and the HI symbol will flash on the panel if the current temperature has been out of range for 15 minutes or more, which means the cold chain has been broken. Take the appropriate steps below if this occurs:

- Immediately move the medication to another medicines fridge and inform the pharmacy team the next working day.

- If medication is needed for administration, contact on-call pharmacist for advice.

If the temperature goes out of range for less than 15 minutes the alarm will not sound. Therefore, it can be assumed that the cold chain has not been broken, and pharmacy advice is needed only if the alarm sounds and panel shows HI.

Labcold Model RLDF0210

If the temperatures goes below +2°C or above 8°C the alarm will sound immediately. Take the appropriate steps below if this occurs. If after 6 hours, the temperature has not returned to an acceptable temperature then take the appropriate steps below

- Immediately move the medication to another medicines fridge and inform the pharmacy team the next working day.
- If medication is needed for administration, contact on-call pharmacist for advice.

High/Low Temperature Alarm

If the temperature in the refrigerator rises above 8°C an alarm will sound and the front panel will display **Hi** and the current temperature inside the fridge alternately.

The cause of the rise in temperature should be investigated **immediately**. Usually, it is simply because the door has been open for a long time, for example while the fridge has been restocked; however, it is recommended that the fridge is checked to make sure that the temperature returns to normal over the next 6 hours.

If the temperature in the refrigerator drops below 2°C an alarm will sound and the front panel will display **Lo** and the current temperature alternately. There could be a number of reasons for this, such as extremely cold items being placed in the fridge.

The cause of the drop in temperature should be investigated **immediately** and the refrigerator should be monitored to check that it returns to the correct temperature over the next 6 hours. Action must be taken by ward staff to find out when the room in which the fridge is located was last accessed to estimate a timescale when the temperature may have gone out of range.

Door Alarm

If the door of the fridge is left open for more than 90 seconds an audible alarm will sound and the front panel will display **door** and the temperature inside the chamber alternately. To silence the alarm, for example while the fridge is being re-stocked, simply press the 'alarm mute' button under the temperature display

If the door has been left open for a prolonged period of time a **Hi** alarm may be heard. This is because warm air from the room will have entered the fridge while the door was open. It is recommended that the door is closed and check that the temperature returns to normal over the next 6 hours.

Note – document actions taken within the notes section on the temperature monitoring form including contacting pharmacy and estates.

Trust pharmacy team contact details

- Lanchester Road Hospital - 0191 4415775
- Roseberry Park Hospital - 01642 838360
- West Park Hospital - 01325 552105
- Cross Lane Hospital - 01723 384638
- Briary Wing, Harrogate Hospital - 01423 553686
 - York Pharmacy, York - 01904717780
 - Medicines Information - tewv.medicinesinformation@nhs.net

- Out-of-hours – [Access to medicines and pharmacy services outside working hours](#)

Security

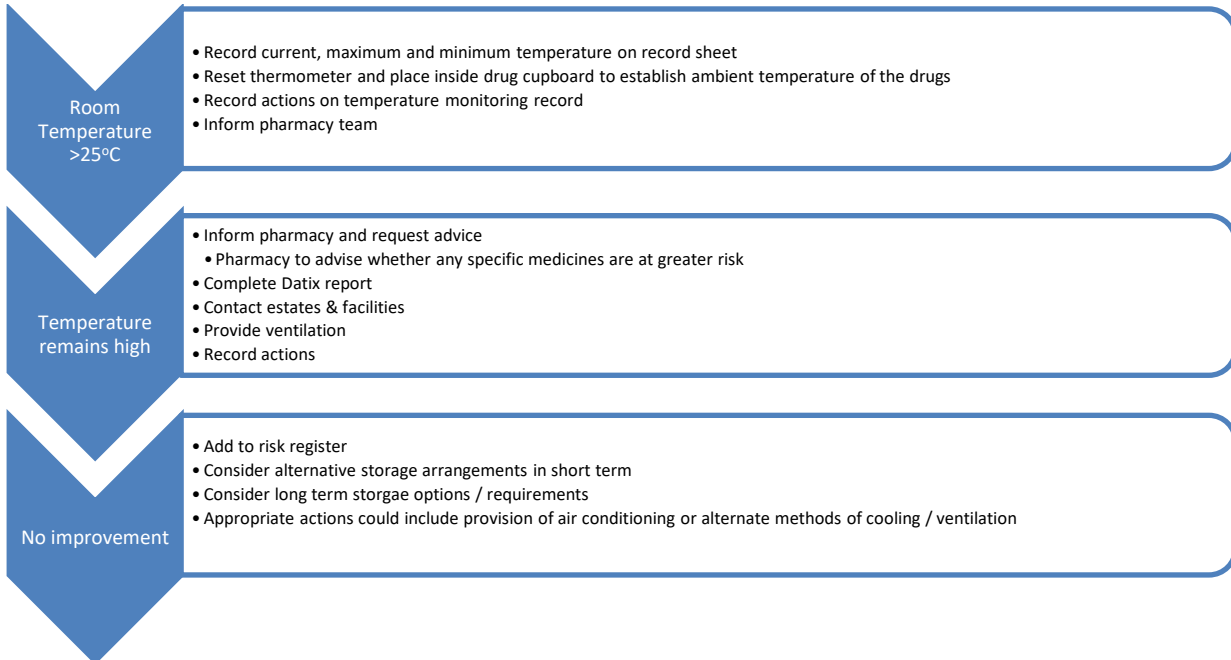
- Medicines fridges must be lockable and must remain locked when not in use.
- The medicines fridge must be kept locked at all times other than when being accessed for medicines

Maintenance of the medicines fridge

- Food, drink or pathological specimens should not be stored within the medicines fridge. (Please note supplement drinks such as Fortisip are acceptable to be stored in the fridge).
- Medicines fridges are to be cleaned with warm soapy water monthly & the date of cleaning is to be recorded on the temperature record log in the notes section.
- The fridge should have auto defrost function, OR should be defrosted every three months. A record of defrosting should be made on the temperature record log follow instructions supplied by the fridge manufacturer.
- Avoid ice build-up by not over stocking or blocking vents
- Avoid prolonged door openings and always make sure the fridge door is closed properly after use.
- Refrigerators should be connected to the mains via a fused spur to prevent the fridge from accidentally being switched off. Only unplug the fridge or switch off for maintenance purposes.
- In the event of accidental switching off or a power failure or temperatures recorded outside the manufacturers' recommended temperature ranges, the pharmacy should be contacted to confirm the medicines remain suitable for use before any are administered.
- Practice good stock rotation principles and ensure longer expiry dated stock of the same drugs are kept at the back (multiple drugs only).
- Only use fingertips with the thermometer (no pens or sharp objects)
- The Trust-approved temperature log sheet must be used.
- Store previous monitoring forms for one year.

Temperature Excursion - Escalation Process

Room



Ambient Medicines Storage Room Temperature Monitoring



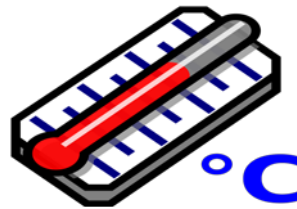
- The ambient temperature of any room used to store medicines outside of a refrigerator must be monitored and recorded at least once daily. This should be documented on the temperature monitoring sheet.
- It is best practice for this recording to take place during the afternoon, in order to account for peak room storage temperatures and enable appropriate action to be taken in a timely manner.

Where the ambient medicines storage room temperature exceeds 25°C:

- Action should be taken locally to reduce this by e.g. opening windows (whilst not compromising medicines security) or switching on available ventilation or air conditioning units
- Document action taken on monitoring sheet.

Where the ambient medicines storage room temperature exceeds 25°C for more than 7 days out of any 30:

- Seek advice from the Pharmacy team on the management of the medicines stored in the room (this may include a reduction in expiry date)
- Seek advice from Estates to identify any adjustments needed to storage room (s)
- Complete Datix Report
- Document action taken on monitoring sheet



Remember the four “R’s”:

- **Read** the thermometer
- **Record** the temperature
- **Reset** the thermometer
- **React** to any temperature excursions

Where the ambient medicines storage room temperature rises above 30°C:

Ward Team:

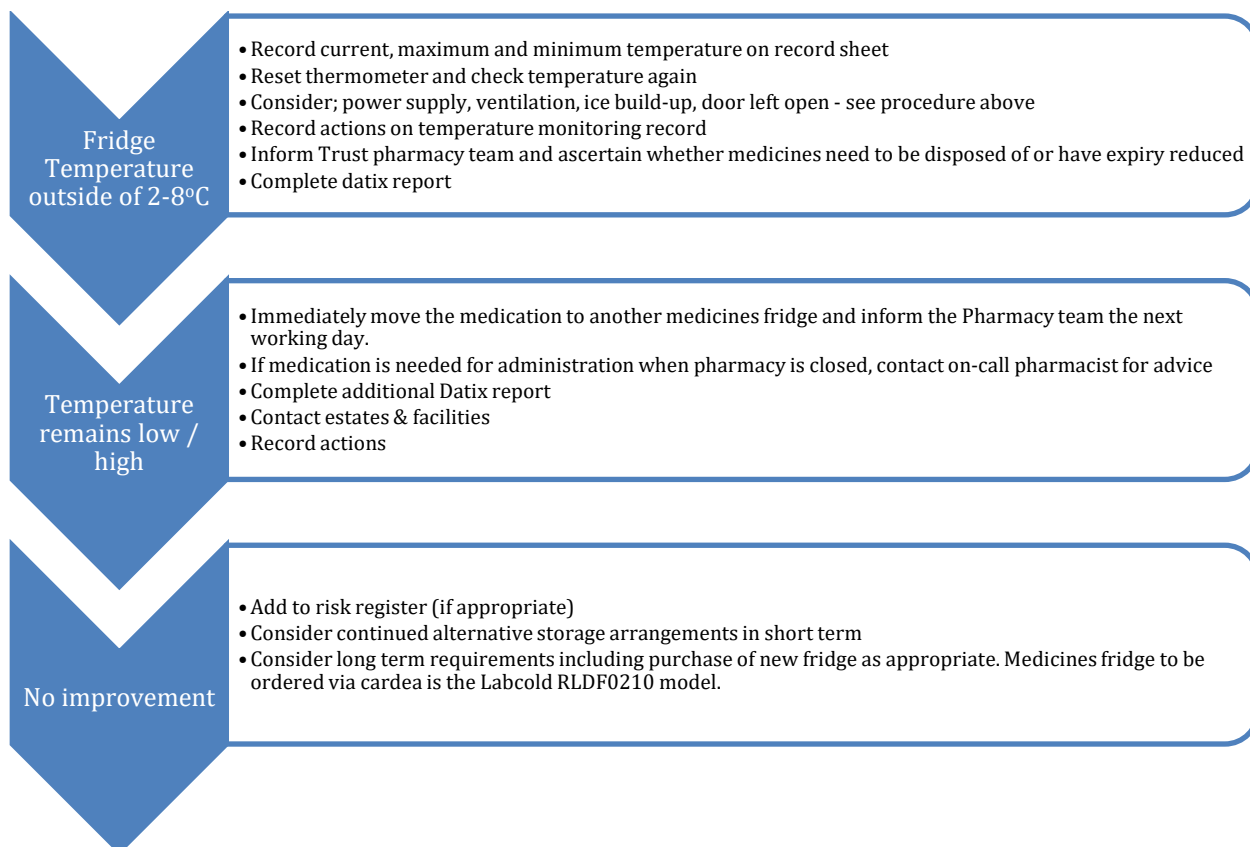
- Inform the Pharmacy team so that specific advice can be provided where necessary.
- Take remedial action to reduce the temperature in the medicine storage room as quickly as possible and document, e.g. windows opened, portable air conditioning unit installed, drugs relocated, etc.
- Document action taken on monitoring sheet
- Visually inspect medicinal products carefully for signs of deterioration regularly.
- Complete Datix report
- Any Controlled Drugs must remain in CD cupboard

Pharmacy Team:

- Consider storing more temperature-sensitive products in the fridge (if space is available) e.g. creams, ointments, suppositories, suspensions, emulsions & insulin
- Mark affected stock with a green cross and date to indicate stock that has been stored in temperatures >30°C and document revised expiry date
- Order non-ward stock (patient specific) items for a maximum of 14 days
- Top up to minimum stock levels only
- Medicine returns from affected wards should not be recycled

Temperature Excursion - Escalation Process

Medicines Fridge



Temperature Monitoring Sheet for Medicines Storage areas and Medicines Fridges

WARD / UNIT:				
MONTH:		YEAR:		Fridge Model:

Date	Time	Fridge Temperature Check Range +2°C to +8°C				Room Temperature Check Temp should be 25°C or less				Staff Initials	NOTES & ACTIONS <small>Document when cleaned / defrosted / alarmed. An action must be recorded for every day a temperature is out of range (e.g. pharmacy contacted, estates contacted, pharmacy risk assessment)</small>
		Actual Temp	Min Temp	Max Temp	Reset	Actual Temp	Min Temp	Max Temp	Reset		
1											
2											
3											
4											
5											
6											
7											
8											
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Completed record checked by:	Date:
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13 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
Dietician	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.
Pharmacy Staff	Pharmacists, Pharmacy Technicians and Pharmacy Assistants employed by the Trust and working within the Pharmacy Service providing a medicine supply, dispensing service, medicine related advice and support medicine related advice and support.

14 How this procedure will be implemented

<ul style="list-style-type: none"> This procedure will be published on the Trust's intranet and external website.
<ul style="list-style-type: none"> Line managers will disseminate this procedure to all Trust employees through a line management briefing.
<ul style="list-style-type: none"> Via medicines management training for Registered Nurses
<ul style="list-style-type: none"> Via Safe and Secure Handling of Medicines for non-registered practitioners

14.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered Nurses	e-learning and face to face	One day	Three yearly
Registered Nurses	Face to face medication	2 hours	Best practice annual though minimum 3

	assessment		yearly
Registered Nurses	Injections Awareness eLearning	1 Hour	3 yearly
Registered Nurses	Controlled drugs eLearning	2 hours	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
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

15 How the implementation of this procedure 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	Identified in procedures	Identified in procedures

16 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

17 Document control

Date of approval:	26 th September 2019	
Next review date:	1 st May 2021	
This document replaces:	V2.1	
Lead:	Name	Title
	Amanda Metcalf	Lead Pharmacy Technician
Members of working party:	Name	Title
	Amanda Metcalf Pharmacy Leadership Team Meeting	Lead Pharmacy Technician
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	26 th September 2019
An equality analysis was completed on this document on:	April 2018	

Change record

Version	Date	Amendment details	Status
2.0	May 2018	Full review	Superseded
2.1	July 2018	Medicines room temp monitoring guide added	Superseded
2.2	July 2019	Updated to reflect Pharmacy Implementation	Approved

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 Service			
Name of responsible person and job title	Amanda Metcalf, Lead Pharmacy Technician – Operational Services			
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Trust pharmacy staff Pharmacy Leadership Team Drug & Therapeutics Committee			
Policy (document/service) name	Medicines – Ordering, storage, transfer, security and disposal			
Is the area being assessed a...	Policy/Strategy	✓	Service/Business plan	Project
	Procedure/Guidance			Code of practice
	Other – Please state			
Geographical area covered	Trustwide			
Aims and objectives	Manage risks with medicines through effective procedures for handling medicines Ensure medicines are supplied, transported, transferred, stored and disposed of in a safe, legal and timely way			
Start date of Equality Analysis Screening	September 2017			
End date of Equality Analysis Screening	April 2018			

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?					
All clinical staff in all services All patients in all services					
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	Sex (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
No – Please describe any positive impacts/s					

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	✓	No	
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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

Yes - service user and carer representatives on D&T committee

No – Please describe future plans that you may have to engage and involve people from different groups

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				
A training need has been identified for;					
Trust staff	Yes	Service users	No	Contractors or other outside agencies	Yes
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: Amanda Metcalf – Lead Pharmacy Technician					Date: 20.4.2018
Your reporting (line) manager: Type name: Chris Williams – Chief Pharmacist					Date: 20.4.2018
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					