Best care by the best people

NELFT NHS
NHS Foundation Trust

MEDICINES

POLICY

Lead executive director:	Dr Trudie Rossouw Acting Executive Medical Director
Lead executive director sign off prior to the approval process:	
Date of sign off by lead executive director:	18.01.2016
Name of originator / author and job title:	Satvinder Bahra Lead Pharmacist
Approved by:	Executive Management Team
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Document Control Sheet

Policy title	Medicines Policy
Policy number	TW/CL0130/v001
Assurance statement	NELFT as a Trust is committed in meeting its governance arrangements in running an efficient service and this policy has been developed to maintain and enhance standards of professional practice on the safe and secure handling of medicines across NELFT and in doing so will minimise the risks of errors and improve patient safety. All staff working within the Trust who are involved in any aspects of medicines usage should familiarise themselves with this and related policies and act in accordance with them.
Target audience (policy relevant to)	All NELFT Staff
Links to other policies	<u>Policies</u> • Assessment of Mental Capacity Policy • Benzodiazepine and Z-hypnotics Prescribing Policy • Central Alerting System (CAS) Policy • High Dose Antipsychotics Prescribing Policy • Administration of Insulin by Healthcare Support Workers/Assistant Practitioners to Adults Policy • Medicines Reconciliation Policy • Non-Medical Prescribing Policy • Rapid Tranquilisation Policy • Resuscitation Policy • Working with Pharmaceutical Industry Policy <u>Formularies</u> • Essex Wound Care Formulary • London Wound Care Formulary • NELFT Psychotropic Formulary • Antibiotic Formulary Flow Chart <u>Guidance</u> • Adult Primary Care Cellulitis Guidelines Essex • Adult Primary Care Cellulitis Guidelines London • Anticoagulation Guideline • Community Initiation of Clozapine Guidance • End of Life and Palliative care: Prescribing advice, contact details and support for staff • Guideline for the Prevention of Venous Thromboembolism (VTE) • Guideline for the management of hypoglycaemia • Guideline for the use of Midazolam for intravenous sedation in the Community Dental Service • Guidelines for the use of the McKinley T34 Syringe pump/driver

	<u>Procedures</u> • The Medicines Standard Operating Procedure • Safe and secure handling of vaccines and refrigerated medicines • Patient Group Directions • Pharmacological management of alcohol and drug dependence in in-patient psychiatric settings • Protocol for use of Melatonin for Diagnostic Hearing Assessment in babies and children <u>Shared Care Guidelines</u> • Shared care guidance for ADHD • Shared care guidance for Alzheimer's • Shared care guidance for Lithium • Shared Care guidelines for Melatonin

Version Control

Version	Date approved	Author(s)	Ratified/ Authorised by	Date	Changes (please identify page no.)
V001		Satvinder Bahra			

Contents

1. Introduction

The format of this policy has been changed to reflect the new organisational structure and this is now an overarching medicines policy.

This policy sets out key principles required to ensure that medicines are managed safely and securely, adhering to legal requirements and clinical recommendations as stated in the following core national documents:

- The Medicines Act 1968 and related Medicines Act Orders [1]
- The Misuse of Drugs Act 1971 and regulations 1975[2]
- The Duthie report1988 and revisions[3] [4]
- The Misuse of Drugs Regulations 2001[5]
- The Safer Management of Controlled Drugs Department of Health, 2006[6]
- Francis Report into the Mid Staffordshire NHS Foundation Trust Public Inquiry. 2010[7]
- Medicines Optimisation: Helping patients to make the most of their medicines Royal Pharmaceutical Society of Great Britain 2013[8]
- Professional standards for hospital pharmacy services, Royal Pharmaceutical Society of Great Britain 2014[9]
- Patient Safety Alerts and Cautions: NHS England, January 2014[10]
- Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE. March 2015[11]
- The Fundamental Standards, Care Quality Commission March 2015[12]

In addition, in response to the fourth report of the Shipman enquiry 2004[13], the government issued new regulations for controlled drugs[14] (CDs) which included provision for the appointment of the Accountable Officer (AO). Within NELFT this is the Chief Pharmacist.

The AO ensures that safe and secure systems are in place for the use and management of controlled drugs. There is regular monitoring and auditing of all processes in the management of controlled drugs and all incidents related to CDs are investigated as part of the medication incident reporting system within NELFT. The AO is part of the Local Intelligence Network (LIN) which includes the police forces, local authorities and the relevant inspection bodies who collaborate and share information about potential offences or actual systems failures.

In response to the NHS England Patient Safety Alert: Improving medication error incident reporting and learning[15], NELFT appointed the Medicines Safety Officer, a senior member of the pharmacy team.

The Drug and Therapeutics Groups report into the Quality and Patient Safety Groups within NELFT and are responsible for the agreement of all medicine related policies, procedures and guidelines. They also agree formularies, review the risk register and monitor compliance with NICE technology appraisals and patient safety alerts and cautions.
This Policy should be read in conjunction with the Medicines Standard Operating Procedure and pharmacy processes included within this document, which give further detail and support in the implementation of the Medicines policy.

There are other specific medicine related policies, procedures, and guidelines which should also be adhered to in conjunction with this policy. (See 'Links to other Policies')
All staff handling medicines should have easy access to the latest version of this document and all other related policies, SOPs, processes and guidelines via the Trust intranet.

2. Aims and objectives

This policy:
Outlines the standards that are set by legislation and professional guidance for the safe and effective use of medicines.

Aims to promote clinical excellence amongst all staff involved in prescribing, administering/supplying, monitoring and review of patients under our care.

Aims to promote independence and empower patients by providing information and involving them in decisions about their medicines.

Encourages reporting of medication incidents with a view to improve patient care, prevent harm and share learning.

3. Definitions and Abbreviations

3a Definitions

Administration
Includes the selection of a single dose of medication from stock or individual patient supply, against a valid prescription from a prescriber, in accordance with a patient group direction or agreed by the trust as a medication exempt from prescribing where an exemption protocol is in place. This is then handed to the patient to take or administered directly by the member of staff for example by injection or topical application.

Authorisation
An authorisation is a document that allows a nurse to administer medication. This includes:

- the inpatient prescription and medication administration record chart
- Direction to administer form (can be a direction to supply and/or administer in certain circumstances)

Community practitioner prescribers
Registered community nurses with additional training able to prescribe licensed medicines listed within the Nurse Prescribers' Formulary for Community Practitioners (NPF).

Controlled drug (CD)
In accordance with the Misuse of Drug Regulations 2001, a controlled drug is a drug or therapeutic agent that requires legal governance around storage, supply and prescribing to prevent being misused, obtained illegally or cause harm.

Direction to administer
A direction to administer is a form/electronic record used to communicate a patient's medication details, against which a registered nurse can administer. In some instances it can act as a direction to supply and/or administer.

The “Direction to administer,” process, under the Medicines SOP, describes the NELFT preferred template for this document however it also details other documents which can be used as the direction to administer where the NELFT preferred template cannot be made available.

Discharge notification
Transfer of care document, communicating a patient’s current medication to the GP and other healthcare professionals involved in the continuing care of the patient, provided at discharge.

Dispense
To prepare a clinically appropriate medicine for a patient, for self-administration or administration by another person. The act of dispensing includes supply and also encompasses a number of other cognitive and practical functions (e.g. checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product). These functions are usually performed under the supervision of a pharmacist.

FP10
FP10s are prescriptions issued by prescribers in community settings or emergency use on inpatient units that can be taken to any community pharmacy for dispensing.

HCA / HCSW
Healthcare assistant/healthcare support worker, works in hospital or community settings, under the guidance of a qualified healthcare professional. The role can be varied depending upon the healthcare setting.

HCPC
Health & Care Professional Council, the governing body for allied health care professionals

Inpatient Prescription and Administration Record Chart (Drug Chart)
Document/electronic record approved by the Trust to be used on an inpatient ward/unit to prescribe and record the administration of medication.

Issuing or supplying medication
The delivery or handing over of medicines, in person, to a patient or carer for the purpose of self-administration by the patient. The medication must have been prepared by a pharmacist and clearly labelled with instructions for administration. .

Licensed medicines
Medicines that have been granted a UK product licence (PL) for marketing authorisation by the MHRA, for UK licence or European Medicines Agency (EMEA), for a Europe wide licence.

Medication error
A medication error is a failure in the treatment process that leads to, or has the potential to lead to, harm to the patient.

Medicine
Any substance or combination of substances presented for treating or preventing disease. Any substance or combination of substances, which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying or maintaining physiological or psychological

functions is considered to be a medicinal product. The following are considered as medicines:

- Controlled Drugs
- Over the counter medicines
- Medical gases
- Dressings
- Complementary medicines

Medicines Management
This term includes the process of medicines being selected, procured, delivered, prescribed, administered or supplied for patient care.

Medicines Optimisation
Looks at how patients use medication over time and focuses on improving the outcomes for the patients not only the processes and systems of medicines Management.

Medicines Safety Officer (MSO)
A senior member of the pharmacy team leading the medicines safety group and an active member of the National Medication Safety Network. Also acts as the link between identifying and implementing local and national medication safety initiatives and daily operations to improve patient safety in the use of medicines.

Medicines SOP
Medicines Standard Operating Procedure for Pharmacy processes and Controlled drugs.

Non-Medical Prescribers (NMP)
A qualified practitioner who can prescribe medication to a patient, within the scope of his/her practice

Non-nursing staff
Staff working in clinical settings who are not registered nurses, and may include social workers, physiotherapists, occupational therapists, healthcare assistants, support staff, outreach workers and psychologists

Nurse
Registered nurse on the appropriate level of the NMC live register.

Off-label
Unlicensed use of a Licensed Medicine

Over labelled medication
A medication in its original container, labelled by a licensed pharmacy/organisation ready for supply to a patient. The label must satisfy legal labelling requirements.

Patient Group Directions (PGDs)
Written instructions for supply or administration of a medicine that applies to a pre-defined group of patients.

Pharmacy Team
Staff employed/contracted by NELFT to provide a clinical pharmacy service.

Pharmacy supplier
The organisation/s contracted by NELFT to supply/dispense medicines.

Pre-pack medication
A medication that has been packed down by a licensed pharmacy/organisation from the original container and labelled ready for use as a stock medication or issued to a patient to take home. Where intended to be supplied to the patient, must satisfy legal labelling requirements.

Prescription
An authorisation from a prescriber to supply medication (this includes FP10 prescriptions)

Patients own drug
Medication brought with the patient on admission (remains the property of the patient) or labelled medication supplied by the NELFT contracted pharmacy.

Record of Administration
A Trust approved form/electronic record which is used to record the administration of medication to a patient (used in all settings except in inpatient settings where an inpatient prescription and administration record chart is in use)

Supervision of self-administration
This is the observation of a patient taking medication that the patient has selected themselves from their own individual supply of dispensed medication. This process may also involve prompting the patient to take the medication.

Supplementary Prescriber
A health professional prescribing under a voluntary partnership with an independent prescriber who must be a doctor or dentist, within the scope of an agreed 'clinical management plan' which is patient specific.

Unlicensed Medicines
Medicines which do not have a UK product licence or a European Union (EU) marketing authorisation.

3b Abbreviations

BNF
British National Formulary
CHS
Community Health Services
CQC
Care Quality Commission
DTG
Drugs and Therapeutics Group
ECT
Electroconvulsive Therapy
GMC
General Medical Council
GPhC
General Pharmaceutical Council
MHRA
Medicines and Healthcare products Regulatory Agency

MHS
Mental Health Service
MSO
Medicines Safety Officer
MSG
Medicines Safety Group
NICE
National Institute of Clinical Excellence
NPSA
National Patient Safety Agency
NMC
Nursing and Midwifery Council
PGD
Patient Group Directions
POD
Patients Own Drugs
SOP
Standard Operating Procedure

4. Roles and responsibilities

4.1 Chief executive
The Chief executive has accountability for ensuring the provision of high quality, safe and effective services within the Trust.

4.2 Executive Directors
Executive Management Team (EMT) are responsible for ratifying all policies and strategies.

4.3 Trust Secretary
Is responsible for ensuring the executive lead signs off all policies after AD approval before presentation to EMT for ratification (note: procedures/guidelines and protocols do NOT require EMT approval).

4.4 Senior Leadership Team (SLT)
Responsible for the approval of all Trust wide procedures/guidelines/protocols.

4.5 Directors
All directors are responsible for the implementation of this policy into practice within their service areas and taking appropriate action should any breach of this policy arise.

4.6 Chief Pharmacist
The Chief pharmacist is responsible for ensuring adherence to this policy across the organisation.

4.7 Accountable Officer
The Accountable Officer is responsible for ensuring the safe and secure management of controlled drugs across the organisation.

4.8 Assistant Directors
All assistant directors have a delegated responsibility for ensuring that this policy is known to all staff and that its requirements are followed by all staff within their area.

4.9 Operational leads

Responsible for:

- bringing to the attention of their staff the publication of this document
- providing evidence that the document has been cascaded within their team or department
- ensuring this document is effectively implemented
- ensuring that staff have the knowledge and skills to implement the policy and provide training where gaps are identified

4.10 Staff

Responsible for:

- adherence to this policy
- ensuring any training required is attended and kept up to date
- ensure any competencies required are maintained
- co-operating with the development and implementation of policies as part of
- their normal duties and responsibilities
- identifying the need for a change in policy as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly
- identifying training needs in respect of policies

4.11 Authors

Responsible for writing the policy, sending out for consultation and making all amendments prior to final sign off.

4.12 Quality and Patient Safety

Responsible for:

- quality checking all documents to ensure both statutory and Trust requirements are met (this is to be carried out via stakeholder consultation)
- publishing approved/ratified/amended documents on NELFT's intranet
- communicating newly approved/ratified/amended documents to Communications for publication in the Trust weekly newsletter

4.13 Communications

Publishing an article in the Trust weekly newsletter indicating all newly approved/ratified/amended documents

5. Processes

5.1 Prescribing medicines

5.1.1 Prescribing can only be undertaken by the following members of staff:

- doctors who are registered with the General Medical Council (GMC)[16]
- dentists who are registered with the British Dental Association (BDA)[17]
- nurses who are registered as prescribers with the Nursing and Midwifery Council (NMC)[18]
- pharmacists who are registered as prescribers with the General Pharmaceutical Council (GPhC)[19]
- All other NMPs who are registered as prescribers with the Health & Care Professions Council (HCPC)[20]

All NMPs must prescribe within their scope of practice and in accordance with the Trust NMP policy.

5.1.2 Prescriptions should only be issued to NELFT patients registered with a GP within the boroughs covered by NELFT services. Exceptions are; minor injuries units, walk in centres and sexual health services where patients are seen and treated outside of the geographical boundaries of NELFT.

5.1.3 Prescribing of medicines must comply with NELFT policies, formularies or joint formularies, agreed at DTG. Medicines formularies can be accessed via the Trust intranet.

5.1.4 Prescribing guidance and shared care guidelines can also be accessed via the Trust intranet.

5.1.5 Prescribing should not be influenced by pharmaceutical industry promotional material and medicine/dressing samples must not be accepted for patient use. For further information refer to working with pharmaceutical industry policy accessible via the Trust intranet

5.2 Writing prescriptions

5.2.1 Prescriptions must be written in accordance with legislation[21] as defined below. Additional legislation applies to CDs. (Refer to Medicines SOP, Process for CDs)

5.2.2 Prescriptions should be written clearly in black indelible ink, must be legible, and preferably in capital letters. Please refer to the BNF[22] for guidance on prescription writing.

5.2.3 Prescriptions must be written on Trust approved documentation ensuring that the contact details of the prescriber are accurate.

5.2.4 Prescriptions on inpatient wards/units should be written on Medication and Administration Record Charts and must be completed, documenting allergy status, details of the adverse reaction, signed and dated.

5.2.5 Outpatient prescribing should only be for medication relevant to the consultation where there is a change of dose or regime and for a maximum of fourteen days.

5.2.6 Where there is no change in medication the GP is responsible for further supplies.

5.2.7 In exceptional circumstances an emergency supply of a medication may be issued on prescription where it is deemed necessary from a patient safety perspective.

5.2.8 All prescriptions including FP10s must include full administration directions. “As directed” should never be used.

5.2.9 Avoid the use of decimal points wherever possible e.g. 500micrograms instead of 0.5milligrams.

5.2.10 All of the following must be included for completeness:

- The British Approved Name of the medicine except when a brand name is clinically appropriate.
- The dose must be expressed in metric units. The word micrograms and units (e.g. insulin) must be written in full. Mcg and iu are not acceptable
- Route
- Frequency
- Form where appropriate e.g. orodispersible tablet
- Type of formulation where appropriate e.g. slow release
- Indication where appropriate e.g. Antibiotic
- Duration where appropriate

5.3 FP10 prescriptions

5.3.1 All FP10 prescriptions written by prescribers must meet the principle legal requirements and have their contact telephone number clearly visible.

5.3.2 Prescribers are not permitted to use Trust prescriptions for staff, family or friends. This is permitted in community based clinics where staff have been referred or self-referred to as a patient e.g. walk in centres.

5.3.3 All FP10 prescriptions are controlled stationary and should be secured at all times

5.3.4 Under no circumstances should blank FP10 prescriptions be signed and left openly.

5.3.5 Lost, stolen or missing FP10 prescriptions must be reported in accordance with the FP10 process (Refer to Medicines SOP, process for the safe and secure handling of FP10's)

5.4 Prescribing of non-formulary, unlicensed or off label medicines

5.4.1 For MHS, the NELFT Psychotropic Drug formulary available via the Trust intranet should always be checked in the first instance.

5.4.2 For CHS, the local Acute Trust formulary for each borough should be followed unless a NELFT specific formulary is available.

5.4.3 Where the medicine is not formulary or established practice nationally, DTG approval should be sought.

5.4.4 Prescribing of non-formulary licensed medicines requires submission of an application to the appropriate DTG for consideration; refer to the medicines SOP for application form.

5.4.5 Prescribing of unlicensed medicines or off-label use should only occur if a licensed alternative medicine is not available/appropriate and is an essential part of the patients care plan.

5.4.6 The unlicensed use must be explained to the patient by the prescriber and a record of consent documented in the clinical notes or electronic record.

(Refer to Medicines SOP, Process for 'Unlicensed medicines/off-labelled medicinal products')

5.5 Prescribing using verbal orders and faxed prescriptions

5.5.1 Verbal orders are not permitted unless in exceptional circumstances where medication is required urgently and a delay would be detrimental to the clinical care of the patient.

5.5.2 A verbal order for a controlled drug is **not permitted** in any circumstances.

5.5.3 A verbal order can only be accepted where the medicine has been previously prescribed and a dose change is considered urgent however, the prescriber is unable to issue a new prescription on the approved paperwork.

5.5.4 The verbal order must be accompanied by a fax or email from the prescriber before administration of medication can take place.

5.5.5 Only registered nurses may accept requests via faxed or emailed verbal orders. Best practice is for two registered nurses (wherever possible) to independently listen to the verbal order to ensure the verbal order is clearly understood.

5.5.6 The fax or email must be printed and attached to the medication administration record chart or authorisation form.

5.5.7 On inpatient units/wards the nurses can document the new dose against the original prescription in the signature box or just above it (where they would normally record administration).

5.5.8 The prescriber must follow up the faxed/emailed verbal order within 24 hours during the week or within 72 hours at the weekend/bank holidays and provide a valid prescription on the approved paperwork for that service.

5.6 Prescribing of alternative remedies

5.6.1 Homeopathic, herbal and complementary or alternative medicines should not be prescribed unless clinically assessed by a prescriber and checked by a pharmacist for interactions

5.6.2 If clinically appropriate, it can be prescribed however the patient will be responsible for arranging further supplies.

5.7 Homely Remedies

5.7.1 Registered nurses can administer a medicine from an agreed list of pharmacy (P) medicines and general sales list (GSL) without a prescription or PGD, in accordance with the Homely Remedies Protocol. Refer to Medicines SOP, Process for 'Homely Remedies')

5.8 Prescribing of medical gases and liquid nitrogen

5.8.1 All medical gases are classified as Medicinal products (as described in the Medicines Act 1968) and must be treated in the same way.

5.8.2 Oxygen for regular use must be prescribed and regularly reviewed by a clinician. Administration of oxygen must be in accordance with The Royal Marsden Clinical Manual[23], which can be accessed via the Trust Intranet.

5.8.3 For emergency use of oxygen see section 5.17.2

5.8.4 For the use of Nitrous Oxide all dental services must follow the NELFT Clinical local procedure (CLP) for the use of inhalation sedation in the community Dental service and ensure safe storage as per the NELFT CLP. Refer to NELFT Dental Services for further information.

5.8.5 Any service using Entonox (Nitrous Oxide and Oxygen) must follow the PGD for its use and ensure safe storage. (PGDs can be accessed via the Trust intranet)

5.9 Ordering/supply of medication

5.9.1 Only those Units/departments within NELFT, with agreed funding, will have access to medicines via the contracted pharmacy supplier. The pharmacy team should be contacted in order to arrange the required medicines.
(Refer to Medicines SOP, Pharmacy Processes for ordering stock and patients own labelled medication')

5.9.2 All controlled drugs must be ordered using the controlled drugs requisition order book and must be signed by the nurse in charge, authorised to order controlled drugs. (Refer to medicines SOP, Process for CDs)

5.9.3 Where controlled drugs are ordered for discharge, the original discharge notification must be collected by the contracted pharmacy supplier before a supply can be made as controlled drugs cannot be dispensed on a photocopied or faxed version.

5.9.4 The contracted pharmacy supplier provides a service Monday to Saturday from 9am to 5pm.

5.9.5 Medication supplies can be obtained in an emergency from designated alternative pharmacy supplier branches from 5pm to 9pm Monday to Friday and 10am to 1pm on Sunday. Transport must to be arranged by the service requiring the emergency order and is dependent on the medication being in stock.
(Refer to Medicines SOP, Process on 'How to obtain medicines out of normal pharmacy hours')

5.9.6 Inpatient units can use FP10 prescriptions to access medication in an emergency from any local community pharmacy however Trust approved transport will have to be arranged by the service requiring the medication.

5.9.7 For the supply of over-labelled or pre-packed medicines against a PGD or an authorisation from a prescriber in HTT or Inpatient ward, refer to the Medicines SOP, Process for supply of over-labelled or pre-packed medicines.

5.9.8 Medication should **never** be re-dispensed in any other container or put in an envelope. All patients must have a fully labelled dispensed medication container from a registered pharmacy as per the legal requirements.

5.9.9 Patients own medication on inpatient units can be relabelled using the mobile relabelling printers in order to facilitate discharge or self-administration. (Refer to Medicines SOP, Process 'Pharmacy Mobile printing and re-labelling and User Manual)

5.10 Transport of medicines

5.10.1 All medicines must be transported by staff contracted to undertake this work for the Trust. This includes approved taxi firms and commercial couriers. All medicines must be transported in opaque, secure and unidentifiable containers.

5.10.2 All service leads must complete a risk assessment to determine the type of container/s most appropriate for transport of medicines within their service. The following must be taken into consideration:

- Size of the container
- Level of security required
- Cold chain maintenance
- Infection prevention
- Durability

5.10.3 All staff authorised by the Trust to carry medicines deemed necessary as part of patients treatment, may use their own vehicle providing adequate business insurance is in place.
Unauthorised passengers should not be carried in vehicles whilst transporting medicines

5.10.4 Medication in a patient's home, no longer needed is the responsibility of the patient, carer or family member responsible for their care.

5.10.5 Registered healthcare professional can remove medication where the family/carer is unable to do so and it is deemed necessary to avoid risk to the patient and/or family members.

5.10.6 Patient, carer or family member consent must be gained prior to removal. The medication must be taken directly to the local community pharmacy for disposal from the patient's home. Consent must be documented in the patient's notes or uploaded on to the patient's electronic records, either Rio or SystmOne and a record made of which medicines were removed, quantities removed and where they were returned to.

5.10.7 Any medicines that need to be returned from community teams must be returned straight away and not taken to other sites/home.

5.10.8 All Trust staff, local pharmacy providers, taxi firms and commercial courier drivers should wear/carry identification badges when transporting medicines. All medicines transported by contracted providers must be carried in designated sealed, tamper evident containers.

5.10.9 Taxi drivers or commercial couriers should not be made aware that CDs are being transported as this may increase the potential for diversion or may discourage the taxi drivers from carrying CDs

5.10.10 Medicines must not be left unattended or unsecured at any time during transport. When medicines are received at their final destination, they must not

be left unattended or unsecured. They should be handed to a registered nurse/reception staff, and locked away in a medicine cupboard at the earliest opportunity or given immediately to the patient/carer.

5.11 Storage and security of medicines

5.11.1 All Medicines cupboards must comply with British Standard 2881:1989[24]. CD cabinets have additional criteria that must be adhered to in accordance with the misuse of drugs regulation[2].

5.11.2 Temperature must be monitored in rooms where medications are stored on inpatient wards and community clinic sites. (Refer to Medicines SOP, Process for 'Temperature monitoring of rooms used for storage of medicines')

5.11.3 The designated manager of an area is responsible and accountable at all times for the storage and security of medication on the ward/department.

5.11.4 The responsibility for all aspects of medicines may be delegated to the registered nurse in charge of a shift for an inpatient unit or the registered nurse in charge of a shift in a community based clinic.

5.11.5 They must ensure that all medicines are stored in designated areas with access restricted to authorised staff only.

5.11.6 All medication should be stored in the appropriate locked facility:

- medicine trolley attached to wall
- internal medicine cupboard
- controlled drug cupboard
- external medicine cupboard
- reagent cupboard
- patient's individual self-administration medicine cabinets
- medicines refrigerator

5.11.7 For the storage and security of controlled drugs, refer to the Medicines SOP, Process for CDs.

5.11.8 An exception to the above are all emergency boxes, emergency drugs and grab bags, which should be readily available in a clinical area. This ensures ease of access in an emergency situation. For a complete list of all available emergency medicines for all locations within NELFT, see appendices 10 and 13 in the resuscitation policy

5.11.9 Medicines for external use should be stored separately from all other medicines.

5.11.10 All medicine cupboards should be kept locked when not in use. Any incidence of tampering or breach of secure cupboards should be reported immediately and investigated by the assigned nurse in charge/team lead. For inpatient wards/units, the ward pharmacist should be involved, for community based clinics a member of the pharmacy team should be consulted.

5.11.11 Under no circumstances may medicines be transferred from one container to another, nor may they be taken out of their container and kept loose,

e.g. ampoules, foil strips or tablets/ capsules in medicine pots. All medication must be kept in the container in which it is supplied.

5.11.12 Pharmaceutical fridges must only be used for the storage of medicines and cool packs used in the transport process. These must have a lockable door, a built in maximum/minimum thermometer, an external probe thermometer and a data logger in place. (Refer to the procedure for the 'Safe and secure handling of vaccines and refrigerated medicines')

5.11.13 Medicines brought from home on admission should be assessed by the pharmacy team and can be considered for re-use. Where deemed appropriate, should be stored in individual self-administration medicine cabinets. (Refer to Medicines SOP, Process for 'Assessing and using Patient's own drugs (PODs) on admission to Hospital')

5.11.14 Controlled drugs brought from home on admission must be stored in the controlled drugs cabinet and recorded in accordance with the CD processes under the Medicines SOP.

5.11.15 In the community where staff are required to administer patients own medication, advice should be given with regards to storage of medication in accordance with the manufacturer's instruction and kept out of the reach of young children.

5.11.16 All services that handle and store oxygen, must have local processes in place to ensure safe storage.

5.11.17 There should be a process for replenishing oxygen cylinders to ensure there is a continuous supply at all times.

5.11.18 For purposes of replenishment and to avoid confusion, empty cylinders must be clearly identifiable from full cylinders.

5.11.19 The oxygen cylinders/piped oxygen on the ward/clinic must be checked daily and recorded. All oxygen cylinders must be secured on a rack, trolley or to the wall. See Medicine SOP, Process of safe and secure storage of Oxygen

5.11.20 All staff handling liquid nitrogen must have attended training to ensure safe handling and storage guidance is followed. Refer to medicines SOP, Process for Safe handling of Liquid Nitrogen)

5.12 Custody and safe-keeping for medicines Key

5.12.1 The designated manager of an area is responsible and accountable at all times for the custody and safe-keeping of medicine keys.

5.12.2 All medicine cupboard keys should be held by the registered nurse in charge, on their person for an inpatient ward or in a designated locked box with limited access for clinic sites.
The keys should not leave the ward/unit/department or be left unattended. For further information on locked boxes and Clinic sites refer to Medicines SOP, Process for 'Secure storage of keys in the community teams'

5.12.3 Keys for ward medicines cupboard, medicines trolleys, medicines refrigerator must be kept together on one key ring reserved solely for those keys.

The keys must be identifiable however not labelled as medicine keys for security purposes.

5.12.4 The controlled drugs (CD) cupboard key must be separated from all other medicine keys, by being on its own key ring.

5.12.5 For Inpatient wards, wherever possible a registered nurse should hold the CD key and another nurse should hold the main set of medicine cupboard keys.

5.12.6 For Inpatient wards, where there is only one registered nurse on duty during a shift, that nurse should hold both sets of keys and at the end of the shift a CD check must be completed in addition to the daily CD stock check (where the daily CD check has already taken place earlier in the day).

5.12.7 For inpatient wards, no one should have access to the CD cupboard except in the presence of the registered nurse officially holding the key. The key must not be handed over to any other health professionals such as pharmacists, doctors or non-medical prescribers (unless that non-medical prescriber is also the qualified nurse responsible for drug administration on the unit)

5.12.8 For CD cupboards on clinic sites, access must be limited to the health professional and nurse authorised to have access. The key should be stored in a locked box and access to the key must be limited as above.

5.12.9 Where a number of practitioners may require access to the medicines cupboard at different times, a system of key security must ensure that only staff who have a legitimate reason for accessing the contents of the medicines cupboard have such access. If a numeric lock is used the number should be changed regularly and after any breaches of security/incidents that may increase the risk of access by an unauthorised person.

5.13 Loss of medicine cupboard keys

5.13.1 Despite thorough checking, if the medicine keys cannot be found:

- Inform the duty senior nurse
- Complete a datix web incident
- Locate duplicate keys
- Take appropriate action as needed to ensure patient safety is not compromised.
- Inform a senior member of the pharmacy team

5.14 Losses and discrepancies of medicines

5.14.1 Any discrepancies or suspected discrepancy in the stocks of medicines must be reported to the nurse in charge/ team lead and the senior pharmacist of the appropriate sector.

5.14.2 Any misappropriation or misuse of drugs by staff will additionally lead to disciplinary action and, if proven, may result in termination of employment and notification to the relevant professional body e.g. NMC, GPhC, HCPC and GMC.

5.14.3 The loss of any medicines from the ward/department must be reported to the nurse in charge as well as the ward/department manager and to the relevant

pharmacy staff and a Datix web report completed

5.14.4 For loss or discrepancies involving Controlled drugs, (Refer to Medicines SOP, Process for CDs)

5.15 Administration of medicines

5.15.1 Any registered nurse employed by NELFT either directly or via an approved agency /NELFT bank may administer medication in accordance with NELFT medicines policy, medicines standard operating procedure and in line with the NMC Code[18] against:

- a prescription and administration record chart by an authorised prescriber (inpatients)
- a PGD
- Direction to administer form (community)

Although NMC guidance[18] requires the original direction to administer to be obtained within 72 hours, the chief nurses have made a decision on behalf of the Trust that this requirement of the original within 72 hours does not apply as long as there is a faxed or emailed version available. The faxed or emailed version must provide assurance that is has been written by the prescriber and it is the final version

5.15.2 A doctor may wish to perform administration in his/her own right, in which case he/she takes responsibility for the whole process, including record keeping and should adhere to the same procedure for administration that would have been followed by a nurse.

5.15.3 Where Trust process requires two registered nurses to be involved in the administration process, the doctor is required to involve a registered nurse in the checking process, see section 5.15.4 below.

5.15.4 On inpatient wards and day hospital settings a second nurse is needed for the administration of the following:

- intravenous injections
- intravenous and subcutaneous infusions (including syringe drivers)
- controlled drugs (Refer to Medicine SOP, Processes for CDs and CD administration flow chart)
- cytotoxic medication (not including oral preparation)
- Depot injections

5.15.5 In community settings the requirement of a second nurse for administration will depend on the individual risk assessment of the clinical setting and competencies related to the administration of the above medicine / formulation

5.15.6 Intravenous medication in any setting can only be administered:

- by staff assessed and recorded as competent by their line manager.
- in accordance with the Royal Marsden competencies and guidance.

5.15.7 Intravenous cytotoxic medication in any setting can only be administered by staff with appropriate training and assessed and recorded as competent by their line manager.

5.15.8 Checking the patients allergy status and expiry date of the medication is a requirement in all settings, before the administration of any medication takes place.

5.15.9 Any medication administered must be documented, signed and dated. Where medication is not administered, this must also be documented, signed and dated, stating the reason for non-administration.

5.15.10 Healthcare assistants (HCAs) can administer insulin in accordance with the 'Policy for the administration of Insulin by Healthcare Assistants/Assistant Practitioners to Adults.

5.15.11 Administration of insulin by a HCA is a delegated task from a nurse who is responsible for ensuring that the HCA has appropriate training, competency and receives adequate supervision to ensure safety of the patient.

5.15.12 The delegation to the HCA of the administration of specific medications covered under Trust policies must be undertaken in accordance with the NMC code[18] and competency must have been assessed by the delegating nurse.

5.16 Emergency drugs for administration

5.16.1 For information on the use of intramuscular adrenaline for management of anaphylaxis, refer to the resuscitation policy. All staff that are authorised to administer adrenaline for anaphylaxis management must have completed the basic life support and anaphylaxis training as per trust guidelines, including HCA's administering insulin.
More information is available from the Resuscitation Council UK[25] and the Trust resuscitation policy accessed via the intranet.

5.16.2 All clinical staff with appropriate training and competence, in line with the Royal Marsden Clinical Manual[23], which can be accessed via the Trust Intranet, may administer oxygen in an emergency without a prescription. A record of administration must be documented in the patients' notes after the emergency procedure.

5.16.3 For information regarding medicines available to manage an episode of hypoglycaemia, refer to the management of hypoglycaemia guidelines (Essex and London). Refer to the specialist diabetes team for guidance.

5.16.4 For information on the availability of first and second line resuscitation drugs on inpatient units or specialised clinic settings, refer to the Resuscitation policy

5.17 Covert administration of medicines

5.17.1 This is defined as administering medicines to patients without their knowledge by disguising a dosage form in some way so that the patient is unaware of the administration. The most common example of this is the crushing of oral dosage forms i.e. tablets, capsules or liquid preparations and mixing them with food or drink.

5.17.2 An assessment of Mental Capacity **MUST** be carried out as per Trust Assessment in line with the Mental Capacity Policy, before any covert administration of medicines takes place.

5.17.3 Covert administration may be considered to prevent a patient from missing out on the process of learning and developing insight which may be an essential element of treatment. The following must apply:

- The best interests of the patient must be considered at all times
- The decision should be made by the multidisciplinary team but taking into account the views of relatives and carers involved in their care.
- The medication must be considered essential for the patient's health and safety and the pharmacist must be involved to ensure the process of medicines administration is appropriate.
- Covert administration should be the least restrictive way of administering the medication in line with Section 1 of the Mental Capacity Act[26]

5.17.4 The covert administration of medicines is only likely to be necessary or lawful in the case of patients or clients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal.

5.17.5 The decision to administer a medication covertly should not be considered routine, and should be a contingency measure. Any decision to do so must be reached after assessing the care needs of the patient individually. It should be patient specific, in order to avoid the blanket administration of medication in this way.

5.17.6 There should be a broad and open discussion amongst the multi-professional clinic team and the supporters of the patient, and agreement that this approach is required in the circumstances. A discussion with the Trust safe guarding team may be necessary.

5.17.7 The decision and the action taken, including the names of all parties concerned, should be documented in the patient records and reviewed at appropriate intervals, in particular taking into account whether the patient continues to lack capacity and whether use of covert medication remains the, most appropriate way of providing treatment. This needs to be documented in the patient's notes or electronic records, either Rio or SystmOne at each patient review i.e. multidisciplinary team meeting and/or ward round.

5.18 Administration of medication to patients admitted out of hours

5.18.1 Inpatient units that do not have a doctor out of hours and no access to an out of hours service to write a medication chart for a patient admitted after the ward doctor has left for the day, should ensure the patient receives all necessary medication safely, until a medication chart can be written. (Refer to the Medicines SOP, Process for Direction to Administer).

5.19 Retention of medicines management records

5.19.1 All medicines management records must be retained for the minimum period as specified in the East of England Recommendations for the Retention of

Pharmacy Records document[27] (Also Refer to the Medicines SOP, Process for 'Archiving of Lloyds Pharmacy Paperwork on the ward)

5.20 Pharmaceutical waste

5.20.1 Stock medication must be used in rotation and expiry checked regularly to avoid wastage (refer to the Medicines SOP, Process for 'Checking of medicines expiry dates')

5.20.2 All out-of-date stock medicines and any other medicines no longer required must be discarded in the appropriate pharmibins, (Refer to the Medicines SOP, Process for 'Safe Disposal of Pharmaceutical waste')

5.20.3 For cytotoxic waste, sharps contaminated with medicines and vaccines. (Refer to the Medicines SOP, Process for 'Safe Disposal of Pharmaceutical waste')

5.20.4 Patients labelled medication supplied by the NELFT contracted pharmacy, that has not expired should be considered for re-cycling in consultation with pharmacy staff, refer to the Medicines SOP, for pharmaceutical waste process, use of patients own drugs process and relabelling of patients own drugs process.

5.20.5 Unwanted controlled drugs must be destroyed by a designated Trust 'witness for destruction" appointed by the Accountable Officer. Refer to Medicine SOP, Process for CDs.

5.21 National patient safety medication alerts

5.21.1 The National Patient Safety Alerting system (NPSAS)[10] implemented by NHS England and the MHRA requires all trusts to improve medication error reporting and maximise learning within all multi-professional groups. The MSO will lead the MSG in order to improve reporting and taking action at local and national level to improve medication safety.

5.21.2 Medication safety alerts and updates will be cascaded by the pharmacy team within the required time frame upon receipt from the health and safety team as per the Central Alerting System [CAS] Policy and will maintain records of all alerts and action taken.

5.21.3 The MHRA urges all healthcare professions to report directly any suspected adverse drug reactions using the Yellow Card Scheme [28] in electronic form on the website or found in the back of the BNF.

5.22 NICE technology appraisals

5.22.1 All NICE technology appraisals will be considered at DTG meetings and records maintained of any actions taken to ensure compliance

5.23 Risk register

5.23.1 A log of all risks added to the risk register will be maintained and discussed at DTG meetings to ensure all medicine related risks are recorded and reviewed at regular intervals.

5.24 Medication errors

5.24.1 All errors, including near misses and potential errors as well as actual medication errors must be reported on the trust local risk management reporting system, Datix web.

5.24.2 A nursing medication administration incident can occur when trust protocol has been followed or as a result of non-compliance with trust protocol. Where the incident occurs as a result of non-compliance with trust protocol, the Medicines administration assessment process for nurses should be followed, refer to Medicines SOP, Process for 'Medicines Administration Assessment for nurses'.

5.24.3 Where Trust protocol has been followed and an incident occurs as a result of medicines administration, an investigation should take place to determine how processes can be improved to prevent a similar event occurring again.

5.25 Clinical trials

5.25.1 Before commencing any clinical trials the Chief Pharmacist or the Deputy Chief Pharmacist/s must be informed and the following considered:

- Ethics and research approval
- Funding approval
- An agreement for the contracted pharmacy for their involvement must be obtained as NELFT do not have their own on site pharmacy.
- Training of staff to ensure understanding of the trial process
- Security and storage of clinical trial medication.
- Break codes in an emergency if double blind
- Record keeping requirements
- Contact details of person to refer patients to that have questions/concerns/side effects
- Follow up process

5.25.2 All clinical trials must have been approved through the NELFT ethic research and development department.

5.25.3 Records will be kept as required of dispensing, issue, administration and disposal of all clinical trial materials.

5.25.4 NELFT pharmacy team must be notified of any trials involving medication.

5.25.5 Safe handling through request, storage, prescribing and distribution procedures should be the same as for all other medicines.

5.25.6 Clinical trial medication may only be stored in the pharmacy.

5.25.7 All patients must give informed consent before participating in a clinical trial.

5.25.8 At the end of the clinical trial where an investigational drug is being reviewed, medication supply can only be continued if defined in the study protocol at the start of the trial.

5.25.9 The sponsor may evaluate the appropriateness of continuing the supply at the end of the trial based on the primary outcome measure and safety data gathered during the study.

5.25.10 The sponsor can make the decision to not supply if sufficient evidence does not exist to support continuation or is defined to that effect at the start of the trial

6 Consent

6.1 Valid consent to treatment is central in all forms of healthcare. "Consent" is a patient's continuing and voluntary agreement for a health professional to provide specific care or treatment to them. Patients may indicate consent non-verbally, orally or in writing. For the consent to be valid, the patient must have capacity in relation to the decision at the time as per the Mental Capacity Act Section 3[26,] that is they must:

- have received sufficient information about their condition and the treatment being offered
- be able to understand the above information
- be able to retain the information long enough to make the decision
- be able to communicate their decision

The consent of the patient must also be given without any undue pressure or duress, otherwise it may be invalid. For further information please refer to the Trust consent to examination and treatment policy

6.2 If there is any indication that the patient may lack mental capacity to consent, a full mental capacity assessment must be carried out and documented in writing. Refer to the Trust assessment of mental capacity policy accessed via the intranet.

6.3 Obtaining consent from children (that is anyone under the age of 16) is more complex and may sometimes be given by the responsible parent or guardian in which case it should be in writing wherever possible. Where a child has been assessed as Fraser (or Gillick)-competent[29], they are able to give consent themselves. Young people (that is, 16 or 17 year olds) have a statutory right to give consent for themselves and there is a presumption that they have capacity to do so. Please refer to the Trust consent to examination and treatment policy for specific guidance on consent in children.

7 Implementation process

7.1 The Trust Medicines Policy will be made available on the intranet and communicated to staff via Quality and patient safety Groups, Drugs and Therapeutic Groups, Medicines Safety Group, Inpatient group meetings, departmental meetings and Pharmacy flyer. Effectiveness of this communication process will be assessed continually via the medicines management audits that are conducted at regular intervals

7.2 The representatives of the above groups need to ensure new policies and procedures are placed on team meeting agendas for discussion. There is an expectation that the team leader will develop local systems to ensure their staff has been instructed to read all relevant policies and to identify any outstanding training deficits.

8 Monitoring arrangements

8.1 The effectiveness of this document is monitored and reported through:

- Bi- Monthly reports to Quality and Safety Groups in the form of exception reports from the Drug and Therapeutic Groups
- Bi-annual reports to Quality and Safety Groups and Quality and Safety Committee

8.2 **Monitoring table**

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Recommendations	Learning lessons
Medication storage and security, compliance with Trust policy	Named Pharmacy Lead	Medicines management audit tool	3 monthly	Deputy Chief Pharmacists, Service Leads, IPAD meetings, DQSGs, DTGs and QSGs	Areas of concern, will be highlighted in the report, and any actions required will need to be agreed within a specified timeframe by the ICD	System or practice changes will be implemented by communication with Directors, Chief nurses, ADs, AMDs and service leads via QSGs, DTGs and DQSGs as deemed appropriate
Adherence to controlled drugs legislation (inpatient wards and home treatment teams)	Named Pharmacy Lead	CD Audit Tool	3 monthly	Accountable Officer, Deputy Chief Pharmacists, ward managers/inpatient matrons, IPAD meetings, inpatient DQSGs, DTGs and QSGs	Areas of concern will be highlighted in the report, and any actions required will need to be agreed within a specified timeframe by the ICD	System or practice changes will be implemented by communication with Directors, Chief nurses, ADs, AMDs and service leads via QSGs, DTGs and DQSGs as deemed appropriate
FP10 prescribing	Named Pharmacy and NMP Lead	EPACT data	Bi-monthly	NMP prescribing leads, NMP Group meetings, DTGS and QSGs	Areas of concern, will be highlighted in the report, and any actions required will need to be agreed within a specified timeframe by the ICD	System or practice changes will be implemented by communication with Directors, Chief nurses, ADs, AMDs and service leads via QSGs, DTGs and DQSGs as deemed appropriate

9 Equality statement

This policy reflects the organisation's determination to ensure that all parts of our community have equality of access to services and that everyone receives a high standard of service as a service user, a carer or employee. This policy anticipates and encompasses the Trust's commitment to prevent discrimination on any illegal or inappropriate basis and recognise and respond to the needs of individuals based on good communication and best practice. We recognise that some groups of the population are more at risk of discrimination or less able to access to services than others and that services can often unintentionally put barriers in place that can limit or prevent access. The organisation is continually working to prevent this from happening.

10 Training

Staff Group	Training topic	Frequency	Who responsible for holding the training	Included in Trust induction (tick)
Nurses	Medicines Policy	Yearly	E-learning	Yes
Doctors (MHS)	Medicines Policy	Once	Pharmacy team	Yes
All clinical staff	Medicines Policy	Additional targeted training on request depending on pharmacy team capacity.	Pharmacy team	No

11. External references

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http://www.legislation.gov.uk/ukpga/1968/67
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2 The Misuse of Drugs Act 1971 and regulation1975
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http://www.legislation.gov.uk/ukpga/1971/38/contents
(Accessed on 23rd October 2015)

3 Department of Health (1988) NHS Executive guidelines for the safe handling of medicines (Duthie Report 1988)

4 Royal Pharmaceutical Society of Great Britain. The safe and secure handling of medicines; a team approach (revised Duthie report) March 2005
http://www.dhsspsni.gov.uk/the-safe-and-secure-handling-of-medicines.pdf
(Accessed on 23rd October 2015)

5 The Misuse of Drugs Act 2001
Great Britain (2001) Misuse of Drugs Act 2001 The Stationary Office, London
http://www.legislation.gov.uk/uksi/2001/3998/pdfs/uksi_20013998_en.pdf
(Accessed 26th October 2015)

6 Department of Health 2006 The Safer Management of Controlled Drugs
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074511.pdf

7 Francis Report into the Mid Staffordshire NHS Foundation Trust Public inquiry. 2010 The Stationary Office, London
http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf
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8 Royal Pharmaceutical Society of Great Britain. Medicines Optimisation. Helping patients to make the most of their medicines 2013
http://www.rpharms.com/what-we-re-working-on/medicines-optimisation.asp
(Accessed 23rd October 2015)

9 Royal Pharmaceutical Society of Great Britain. Professional standards for hospital pharmacy services. Optimising Patients Outcomes form Medicines Version 2 July 2014
http://www.rpharms.com/support-pdfs/rps---professional-standards-for-hospital-pharmacy.pdf
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10 NHS England, National Patient Safety Alerts January 2014
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https://www.nice.org.uk/guidance/ng5
(Accessed on 23rd October 2015)

12 Care Quality Commission, standard for Hospitals, Mental Health and Community Health Services March 2015
http://www.cqc.org.uk/content/hospitals-mental-health-and-community-health-services#handbooks
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13 The Shipman Inquiry. Fourth Report: The Regulation of Controlled Drugs in the Community (Cm6249). The Stationery Office July 2004

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214915/15-02-2013-controlled-drugs-regulation-information.pdf
(Accessed on 23rd October 2015)

15 NHS England, National Patient Safety Alerts January 2014.Improving medication error incident reporting and learning March 2014
https://www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-error.pdf
(Accessed on 23rd October 2015)

16 General Medical Council 2010 London (GMC)
http://www.gmc-uk.org/doctors/register/LRMP.asp
(Accessed 11th November 2015)

17 British Dental Associations (BDA)
https://www.bda.org/ (Accessed 11th November 2015)

18 The Nursing and Midwifery Council. NMC's Standards for Medicines Management April 2010
http://www.nmc.org.uk (Accessed 12th November 2015)

19 The General Pharmaceutical Council (GPhC)
https://www.pharmacyregulation.org/ (Accessed 24th November 2015)

20 The Health and Care Professions on Council (HCPC)
http://www.hcpc-uk.org/ (Accessed 24th November 2015)

21 Royal Pharmaceutical Society of Great Britain. Medicines, Ethics and Practice Guide edition 39 July 2015, The Professional guide for pharmacists.
http://www.rpharms.com/support/mep.asp
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22 British National Formulary
http://www.bnf.org/ (Accessed via internet 11th November 2015)

https://www.medicinescomplete.com/mc/bnf/current/ (Accessed via MedicineComplete via the Trust intranet 11th November 2015)

23 The Royal Marsden Manual 9th Edition Online
http://www.rmmonline.co.uk/
(Accessed via the Trust intranet 12th November 2015)

24 BS 2881: 1989 Specification for cupboards for the storage of medicines in health care premises
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www.resus.org.uk
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http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/menincap/legis.htm
(Accessed 15th December 2015

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https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/
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Stakeholder form

Stakeholder title	Date sent to Stakeholders	Comments received	Returned, no comments	Not returned
Equality and Diversity Manager	7 December 2015	✓		
Leadership Team – Basildon and Brentwood Locality	9 December 2015			✓
Leadership Team – Barking and Dagenham Locality: Sangita Lall, Assistant Director Community Health Services Julie Myles, Integrated Community Services Manager	9 December 2015	✓ ✓		
Leadership Team – Havering Locality	9 December 2015			✓
Leadership Team – Redbridge Locality	9 December 2015			✓
Leadership Team – Thurrock Locality: Vikki Harding, Assistant Director Thurrock Children's Services and Sexual Health Services	9 December 2015		✓	
Leadership Team - Waltham Forest Locality	9 December 2015			✓
Leadership Team - MHIPAD: Lorna Mess, Modern Matron, Older adults inpatient wards.	9 December 2015	✓		
Chief Nurse Group - Colette.tolladay@nelft.nhs.uk	9 December 2015			✓
Compliance Team (QPS) policies@nelft.nhs.uk	9 December 2015	✓		
Director of Nursing (Clinical Effectiveness – Susan.Smyth@nelft.nhs.uk Practice Improvement Practitioner: Kelly Anderson Andrea MacKay	9 December 2015	✓ ✓	✓	
Director of Nursing (Patient Safety, BTUH Health Economy) – Diane.Searle@nelft.nhs.uk]	9 December 2015			✓
Director of Nursing (Patient Experience) Debbie.Smith@nelft.nhs.uk	9 December 2015			✓
Associate Director of Nursing Quality & Patient Safety Alison.Garrett@nelft.nhs.uk Robert Keys, NELFT Law Manager	9 December 2015	✓		
Head of Health and Safety	9 December 2015			✓
Head of Information Governance	9 December 2015			✓
Associate Director of Human Resources Yvonne.Hood@nelft.nhs.uk	9 December 2015			✓
Finance Malcolm.Young@nelft.nhs.uk	9 December 2015			✓
Performance Graham.Blowes@nelft.nhs.uk	9 December 2015			✓

Estates – Havering/Basildon/Thurrock Martin.Mizen@nelft.nhs.uk	9 December 2015			✓
Interim Head of Estates (WF/Red/B&D) David.Bays@nelft.nhs.uk	9 December 2015			✓
Communication team Communications@nelft.nhs.uk	9 December 2015			✓
Pharmacy Team .NELFT@Nnelft.nhs.uk	19 October 2015	✓		✓
CHS DTG	26 November 2015	✓		
MHS DTG				✓

NELFT

INITIAL SCREENING EQUALITY IMPACT ASSESSMENT FORM

Directorate/Department	**Medical**
Name of Policy/Service/Function	**NELFT Medicines Policy**
New or Existing Policy/Service/Function?	**New**
Name and role of Person completing the EQIA	**Harjit Bansal**
Date of Assessment	**8/12/2015**

		Yes/No	What/Where is the Evidence to suggest this?
1	**Does the Policy/Service/Function effect one group less or more favourably than another on the basis of:**		
	• Race, Ethnic origins (including, gypsies and travellers) and Nationality	Yes	Where English is not their first language; every effort should be made to contact interpreting and translation services. Information leaflets about medication should also be made available in different languages and formats where ever possible and when requested by patients.
	• Gender (males and females)	No	There may be some impact for women, who may be pregnant or breastfeeding.
	• Age	Yes	Based on clinical decision, age may affect the choice of medication/dose e.g. renal failure. However this decision is made to ensure patient safety. Administration of medication for children and information available in a format that it easy for children and young people to relate to. Medication for older adults, and those who would require information in a large font. Have systems in place to work in partnership with carers for patients with dementia and other physical and complex health issues. Again, it is important to ensure that information is available in a format that is easy to read (simple and Plain English) for consent to be given).
	• Religion, Belief or Culture	Yes	There is some evidence for particular groups, who require medication, but may be fasting as part of their religious or cultural belief system. There is no evidence to suggest that the policy will have an impact on those with a religious/belief. However, every effort will be made to address the religious/belief systems of patients during their care. Staff should read guidance on supporting patients

			during Ramadan e.g. when fasting.
	• Disability – mental, physical disability and Learning difficulties	Yes	Information should be made available in an appropriate format wherever possible, for those with sight and hearing problems. Those with learning disabilities, information should be made available in easy read, braille, audio, large print and patients should be informed of any side effects.
	• Sexual orientation including lesbian, gay and bisexual people	No	There is no evidence currently to suggest that the policy will have an impact due to difference in sexual orientation.
	• Married/or in civil partnership	No	There is no evidence currently to suggest that the policy will have an impact due to difference in either case.
	• Pregnant/maternity leave	No	Based on clinical decision, pregnancy may affect the choice of medication/dose. However this decision is made to ensure patient safety. Should also risk assess if patient is breast feeding.
	• Transgender reassignment	No	There is no evidence to suggest an impact on Transgender groups; however, some of them may be undergoing major/minor operative procedures to change from one gender to another, which may have an impact. Staff should be aware of what these are (or of any likely side effects).
2	**Is there any evidence that some groups are affected differently? Is the impact of the policy/Guideline likely to be negative?**	Yes	
3	**Is there a need for additional consultation e.g. with external organisations, service Users and carers, or other voluntary sector groups?**	No	
4	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	Yes	
5	**Can we reduce the impact by taking different actions?**	Yes	Audit the impact of the policy on the 9 protected characteristics. Access number of incidents by the 9 protected characteristics. Ensure a process in place for translating or transcribing medication leaflets in easy read, large print, and different languages when requested.

Assessor's Name: Satvinder Bahra **Date: 30.11.15**

Name of Director: Heather Walker

This section to be agreed and signed by the Equality and Diversity Manager in agreement with the Equality and Diversity Team

Recommendation

Full Equality Impact Assessment required: NO √ YES □

Assessment authorised by:

Name: Harjit K Bansal, Equality and Diversity Manager

Date: 8th December 2015

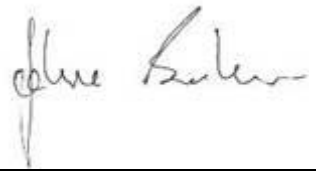
Approval Checklist – for the Review and Approval of Policy and Operating Procedures or Guidelines

To be used as a guide to quality check that Policy and Guideline practice has been implemented before submitting for approval. If you have answered "No" to any of the questions, your document will NOT be accepted for ratification

	Checklist	Yes/No	Comments
1	Does your document follow the current template for Policies/Procedures/Guidelines available on the Trust website?	Yes	
2	Is the title clear – has best wording been used in order that staff can locate policy easily? Is this in the correct style and format (Arial font size 11, left justified throughout)?	Yes	
3	Are all paragraphs and sub-paragraphs numbered? Have bullet points been used appropriately, i.e. only for short lists and not in place of paragraphs?	Yes	
4	Is the front sheet fully completed?	yes	
5	Does it have the correct version number?	Yes	
6	If this is a clinical adult guideline check to see if listed in Royal Marsden on-line manual. If so can Royal Marsden guideline be used? On-line manual accessed via Trust Intranet	NA	
7	CQC – Does your policy/procedure/guideline reflect the criteria within the CQC's 5 Key questions - that services deliver Safe, Caring, Responsive, Effective and Well led care?	Yes	
8	Is the monitoring process clearly described and monitoring table within template complete?	Yes	
9	Any training aspects of policy/procedure identified? Follow-up procedures listed.	Yes	
10	Does this document link to any NELFT policies? Are they listed on document control sheet?	Yes	
11	Are the references listed up-to-date and appropriate?	Yes	
12	Have you carried out a robust stakeholder process, ensuring those listed in the template as stakeholders are consulted and is the stakeholder form comment box complete?	Yes	
13	Is the Equality Impact Assessment tool fully completed, individualised to this document and approved - have you received a signed authorised copy back from Equality and Diversity team?	Yes	
14	If you have attached appendices are they appropriate, referred to within the document and listed on contents page?	NA	
15	Regarding HR policies – have they been signed off by the Joint Negotiating Consultative Committee (JNCC) prior to submission to the ratification process?	NA	
16	Finally have you carried out a final proof-read, checked all spellings and ensured your document is accurate and ready for publication?	Yes	

EMT APPROVAL SHEET

Policy title:	Medicines Policy
Author:	Satvinder Bahra
Lead Executive Director approval	Dr Trudie Rossouw Acting Executive Medical Director

Meeting	Date of meeting	Chair name and title	Signature of Lead Director/ EMT Chair	Approved ? Y / N	Reason for non-approval
EMT	21.01.2016	John Brouder		Y	

Once the form has been agreed/not agreed for ratification by the Executive Management Team the Trust Secretary should send to policies@nelft.nhs.uk as confirmation of approval

Addendum

Date	Section	Change	Agreed by