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Royal Cornwall Hospitals NHS Trust

The Medicines Policy

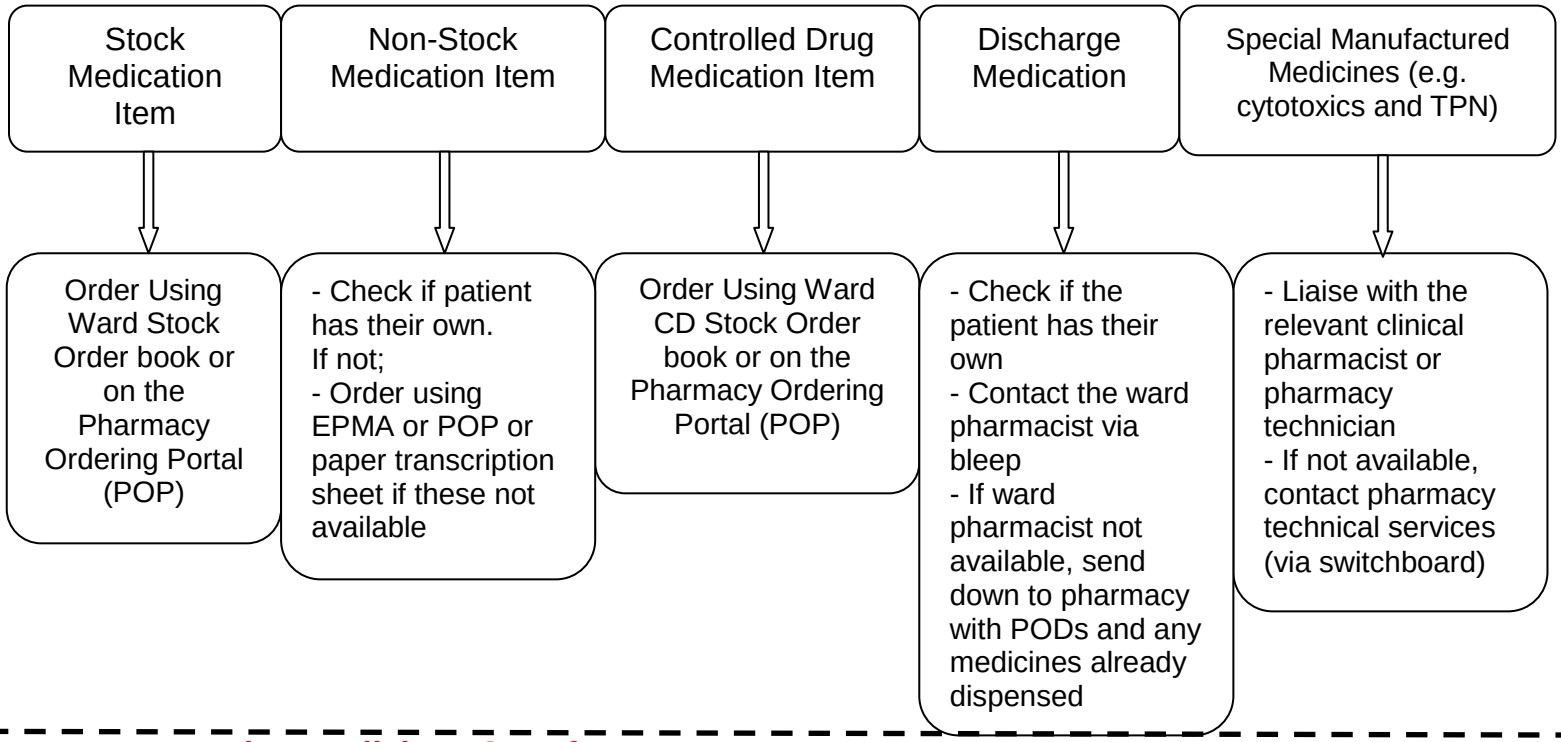
Chapter 3: Ordering and Accessing Medicines

V3.0

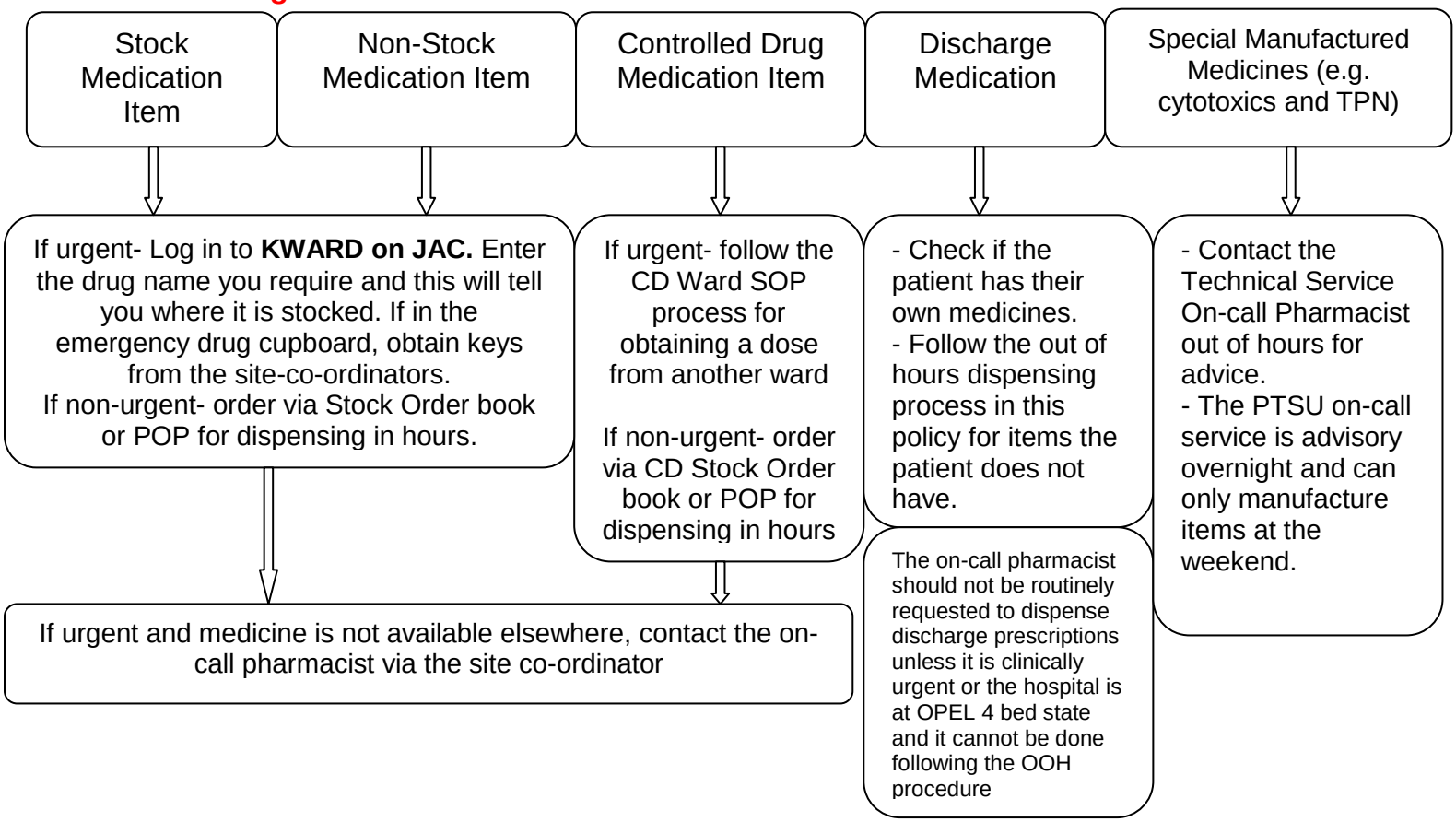
December 2018

Summary.

Accessing Medicines In-hours (08.30 to 17:00, 7 days a week)



Accessing Medicines Out of Hours



THE PHARMACY ON-CALL SERVICE IS A NON-RESIDENT EMERGENCY SERVICE.
THE ON-CALL SERVICE IS MAINLY FOR CLINICAL ADVICE. FOR SUPPLY ISSUES IT SHOULD ONLY BE USED FOR URGENT ITEMS THAT CANNOT BE OBTAINED FROM THE OUT OF HOURS CUPBOARDS OR OTHER WARDS

Table of Contents

1. Introduction

1.1. Medicines are the most common healthcare intervention used within the Trust. Appropriate use of medicines can deliver great benefits to patients; conversely inappropriate use can cause patient harm. This chapter of the medicines policy details how to access medicines for our patients and should be read in conjunction with the 'Clinical Guideline for Ward Medicines Management';

1.2. Virtually all medicines are subject to the controls imposed by the Human Medicines Regulations 2012 (S.I. 2012/1916), which were laid on 24 July 2012 and came into force on 14 August 2012. These regulations were a consolidation of the Medicines Act 1968 and the very many orders made under that Act.

1.3. Some medicines are further governed by the provisions of the Misuse of Drugs Act 1971 and The Controlled Drugs (Supervision of Management and Use) Regulations 2013. There are complex and significant restrictions placed on the way *Controlled Drugs* may be handled within the Trust, these are described fully in the Trust's Controlled Drug Policy.

1.4. Throughout, the convention is used that the words "shall" or "must," indicate actions which are mandatory – either because they are legal requirements, or because the Trust, through the Medication Practice Committee, has decided that they will be mandatory. Other instructions may be taken to be best practice.

1.5. This version supersedes v2.2 of Chapter 3 of this policy, previously entitled 'Ordering Ward Stock and Non-Stocks Inpatient Items'.

2. Purpose of this Policy/Procedure

2.1. Ensuring the right medicine is available for the right patient at the right time is a vital element of safe patient care.

2.2. Ensuring that staff know how to order and access medicines both in and out of hours.

2.3. To prevent missed doses of medicines due to medication unavailability.

3. Scope

3.1. This chapter of the Medicines Policy is the overarching document that covers how RCHT staff order and access medicines and covers all RCHT activity and staff employed by RCHT. There are related policies that deal with specific aspects of medicines in more depth. These are referenced in this policy and can be found on the Trust document library.

3.2. Controlled drugs are subject to stringent control dictated by legislation. The Trust Controlled Drugs Policy can be found through the document library.

3.3. The key guideline for wards and clinical areas relating to this policy is the CLINICAL GUIDELINE FOR WARD MEDICINES MANAGEMENT

4. Definitions / Glossary

Stock Medicine
A medicine held as stock by the clinical area. These medicines are usually medicines that are frequently used in the clinical area, or medicines that might be required in an emergency.

Non- Stock Medicines
These are medicines that are not stocked in the clinical area and are specific to the individual patient.

Controlled Drug
These medicines are governed by the provisions of the Misuse of Drugs Act 1971 and The Controlled Drugs (Supervision of Management and Use) Regulations 2013. Clinical areas will hold a defined list of CDs as stock.

Specials- Manufactured Items
These medicinal products are produced within the pharmacy technical services unit (PTSU) and generally require complex aseptic preparation, either to protect the patient, the staff or both. Such products include chemotherapy, TPN and radio-isotopes.

On-call Pharmacist
Pharmacy provides an on-call service out of hours for both clinical/supply services and for Pharmacy Technical Services. The on-call is a non-resident service and is mainly advisory in nature. Urgent items will be supplied if they cannot be sourced elsewhere. Specials items are not manufactured overnight by the on-call PTSU pharmacist but only by the full on-call weekend PTSU team.

5. Ownership and Responsibilities

This policy is owned by the chief pharmacist who has been nominated by the Medical Director to be the responsible for this policy.

5.1. *Role of the Managers*

All managers of areas where medicines are prescribed, stored and/or administered should ensure that their staff have read and understood the policy and have attended the appropriate training as set out in the Trust training needs analysis.

Managers in these areas are also responsible for ensuring that their staff follow the guidance set out in this policy and report incidents where this is not the case.

Managers must understand the implications to patients and availability of medicines when agreeing to outlie patients or designate a clinical area for a new speciality. Such changes mean the established stock lists will not match the patient cohort, increasing the risk of missed doses of medicines and patient harm. A clinically led stock-list review should happen in these instances.

5.2. *Role of the Group/Committees*

5.2.1 Medication Practice Committee (MPC)

The MPC is the committee responsible for oversight of this policy and its implementation. The MPC has a number of sub-committees responsible for the

governance of specific areas of medicine's practice e.g. antimicrobial stewardship and chemotherapy.

5.2.2 Medication Safety Group (MSG)

The MSG is responsible for reviewing medication related incidents and other reported breaches of the policy, recommending suitable actions to the MPC and ensuring that any learning is shared across the organisation.

5.2.3 Cornwall Area Prescribing Committee (CAPC)

The CAPC is responsible for agreeing the drug formulary for Cornwall. This can be found on the Trust intranet (and internet) through the A-Z Resources/ Formulary (joint). The committee is also responsible for medicines optimisation across all healthcare sectors in Cornwall.

5.3. *Role of Individual Staff*

All staff involved in the medication process should ensure they have read and understand the relevant section of the policy and have attended the appropriate training as set out in the Trust training needs analysis.

5.3.1 **The prescriber (medical practitioner or non-medical prescriber)**

All prescribers should be familiar with the GMC guideline 'Good practice in prescribing and managing medicines and devices' (2013) and the Public Health England document 'Antimicrobial Prescribing and Stewardship Competencies'.

Prescribers shall endeavour to inform the nurse looking after the patient when a new medicine has been prescribed to enable the nurse to order the medicine if required and to ensure that the patient does not miss a dose.

The prescriber must prescribe according to the Cornwall Medicines Formulary and understand that prescribing off formulary will likely mean the pharmacy will not stock the medicine and therefore the patient is at a higher risk of not receiving the medicine.

Prescribers must also react to local and national supply shortage issues and adjust their prescribing accordingly, to a medicine that is routinely available.

5.3.2 **The Pharmacist**

The Pharmacist must ensure that all medicines prescribed to be taken regularly, including as required medicines, are supplied to wards and departments as requested.

Pharmacists should provide appropriate information and advice to medical and nursing staff on all pharmaceutical aspects of medicine therapy. They should review/annotate the prescription to eliminate ambiguities and raise any apparent error with the prescriber.

The pharmacist must review the drugs prescribed on a regular basis. This review should include a check that the patient has been receiving their medication. Where missed doses are identified, this should be escalated to the ward sister

and a Trust incident form completed if appropriate. (Refer to *the Delayed and Omitted Doses of Medicines Policy*).

5.3.3 **Nurse/midwife (or any health professional administering a medicine)**

The nurse/midwife (or allied health professional - AHP) must understand the process for ordering and accessing medications as set out in the clinical guideline for ward medicines management.

They must first ask if the patient has brought in their own medicines with them, or whether a family member can bring them in, before placing an order with pharmacy to supply.

They must understand the risks of missed doses of critical medicines (Refer to *the Delayed and Omitted Doses of Medicines Policy*) and know how to access these medicines both in and out of hours.

They must ensure that the patient's medicines are transferred with the patient when moving to other wards, community hospitals etc., to ensure the patient continues to have access to these medicines and does not miss doses.

Where it is not possible to administer a medicine, the reason should be documented on the drug chart. Where the drug is not available every effort should be made to obtain this medicine, either from pharmacy during normal hours, or from the Emergency Drug Cupboards, another ward or the on-call pharmacist, out of hours. (Refer to the Trust *Delayed and Omitted Doses of Medicines Procedure*).

5.3.4 - **Non-registered Healthcare Professionals**

There are some specific situations where non-registered healthcare professional are allowed to prepare or administer medicines. Such arrangements will have been documented and approved by the Medication Practice Committee and it is the responsibility of the non-registered healthcare professional to follow those arrangements.

6. Standards and Practice

6.1. Ordering Ward Stock and Non-stock Inpatient items

6.1.1. Ordering Medicines

Within wards and departments, medicines can conveniently be classified as either "stock" medicines – in which case the supply is held by the ward for use on any patient as required – or as "named patient" / "non-stock" medicines – in which case the supply is labelled for, and may only be used by, a single named patient. Separate procedures are in place for each class of medicine.

6.1.2. Medicines For Stock

There are three ways in which wards and departments are supplied with stock medicines:

6.1.3. Pharmacy top-up: A system of supply in which pharmacy staff maintain ward or department stock levels in accordance with a stock list that is approved by the Ward or Department Manager. Pharmacy staff will ascertain how much stock is required and then put this stock away. Ward staff will only rarely need to become involved in ordering stock medicines.

For wards with Omnicell electronic drug cabinets, the cabinets automatically order medicines from the pharmacy when a pre-set minimum level is reached. Pharmacy staff may then come and place the stock in the cabinet as part of the top up service.

Wards and departments are topped-up on specific days of the week. Contact the pharmacy department to find out which days an area is topped-up. Not all clinical areas receive a pharmacy top-up service.

6.1.4. Ward staff top-up: Ward staff complete the ward stock check and order the required stock medicines either via annotating the ward stock-list with the quantities required or via the Pharmacy Ordering Portal, or via the Omnicell re-ordering process. Pharmacy then processes the order and sends it to the clinical area but do not put the stock away.

6.1.5. Ad-hoc stock ordering:

- Stock medicines are ordered in a ward requisition book (CHA49), or by using the electronic Pharmacy Ordering Portal (POP).
- For paper orders a Registered Healthcare Practitioner must sign the order, and PRINT their name alongside. The pink copy of the order may be retained on the ward for checking purposes.
- The requisition book should then be sent down to pharmacy by the ward staff, porter or ward pharmacist.
- For bulk fluids use the bulk fluids requisition form.
- For enteral feeds use the enteral feed requisition form.
- POP orders will print out in the pharmacy department and do not need to be sent down to pharmacy.

It is the ward's responsibility to provide pharmacy with an up to date list of authorised signatories for those staff that can order medicines.

6.1.6. Medicines for Named Patients (non-stocks)

6.1.6.1. Ward staff are encouraged to use Patient's Own Medicines (PODs) whenever possible.

6.1.6.2. When PODs are not available and the medicine is not stocked on the ward, named patient medicines may be ordered by any registered healthcare professional on POP.

6.1.6.3. On wards where POP is not available staff should order non-stock medicines via the JAC EPMA system by adding a '**Order from Pharmacy**' note to the drug that is required.

6.1.6.4. For non-POP and non-JAC EPMA areas use the paper transcription sheets.

6.1.6.5. The non-stock orders will automatically be printed and dispensed in pharmacy.

6.1.6.6. Items that are non-formulary will not automatically be dispensed and we will routinely ask the patient to bring in their own supply. This also applies to other items such as inhalers.

6.1.6.7. Restricted items, such as certain antibiotics, may only be supplied after discussion with the ward or the prescriber.

6.1.7. Ordering Medicines for Discharge

6.1.7.1. Only newly initiated items should be dispensed at discharge, provided the patient has sufficient supply of their regular medicines with them or at home.

6.1.7.2. Before a discharge prescription is dispensed in pharmacy, the ward staff need to ascertain whether;

- The patient already sufficient supply at home.
- The patient has PODs with them on the ward.
- Labelled named patient supplies for the patient have already been dispensed and are on the ward.

6.1.7.3. This step can be undertaken by the medical, nursing or pharmacy staff on the wards and is crucial to expediting discharge and reducing wastage.

6.1.7.4. The printed TTO and any patient's own medicines or dispensed named patient items should be given to the ward pharmacist/ technician or sent to pharmacy. The pharmacy team will then assemble the discharge medicines as necessary.

6.1.7.5. When discharge medications are received on the ward well in advance of discharge they must be secured in a locked cupboard. If they include items requiring refrigeration, these should be placed in the medicine refrigerator with a note attached to the bag of remaining medicines. If they include controlled drugs these should be locked in the CD cupboard, recorded in the 'patient's own' section of the ward controlled drug register, and booked out to the patient on discharge.

6.1.7.6. When the patient is actually discharged, the nurse must follow the prompts on the discharge checklist and check that all prescribed items – whether dispensed from Pharmacy or patient's own – are in the bag (including refrigerated and CD items) or that the patient has sufficient supply at home, and that the patient or carer knows how to take or administer them. Carefully check for any changes on the discharge prescription that might have happened since the medicines were dispensed. Ensure the patient receives a printed copy of the discharge summary before they leave the hospital.

6.1.7.7. When the discharge prescription has been completed and printed by the prescriber, nurses should check whether any of the patient's own medicines or named patient supplies are being held on the ward.

6.1.8. Using Ward Prepacks for Discharge Prescriptions

All prescriptions must be checked for appropriateness before the TTO is assembled. The check (carried out by the nurse assembling the prescription or by the ward pharmacist if available) will include:

- Patient details
- Allergies
- Doses
- Contra-indications
- Interactions including patients regular medications
- Side-effects
- Antibiotics prescribed should have their indication and course length clearly documented

6.1.8.1. For each medication that is dispensed by pre-pack from the TTO pre-pack cupboard the nurse will check the following particulars to ensure they have the correct medication pre-pack and it is in date:

- Name of drug (against the prescription).
- Strength medication (against the prescription).
- The expiry date of the medication.

6.1.8.2. The label affixed to a pre-pack has a set wording with blank spaces left for the dispenser to populate; this should not be amended in any way. The dispenser will need to ensure the following:

- The patient's name is filled in in the space provided.
- The date of dispensing is filled in in the space provided.
- Where spaces are provided, to fill in the dose and frequency in accordance with the prescription.
- If there are no spaces provided for filling in the dose and frequency that the set wording given for the dose and frequency is in accordance with the prescription.

6.1.8.3. Once the "dispenser" is satisfied with the labelling of the pre-pack medication they need to sign the label of each pre-pack they have dispensed. The dispensing nurse will then need to endorse (in the spaces provided on the discharge prescription) the quantity of each medication they have dispensed and that they have dispensed it. The nurse should also ensure that a patient information leaflet is included with each pack. The assembled prescription then needs to be checked by a second nurse or a pharmacist.

6.1.8.4. The completed paperwork will then be filed in the designated location (as agreed with the ward pharmacist(s)) for collection and retrospective review. After collection the completed paperwork will be filed and stored in pharmacy department. If the TTO has not been

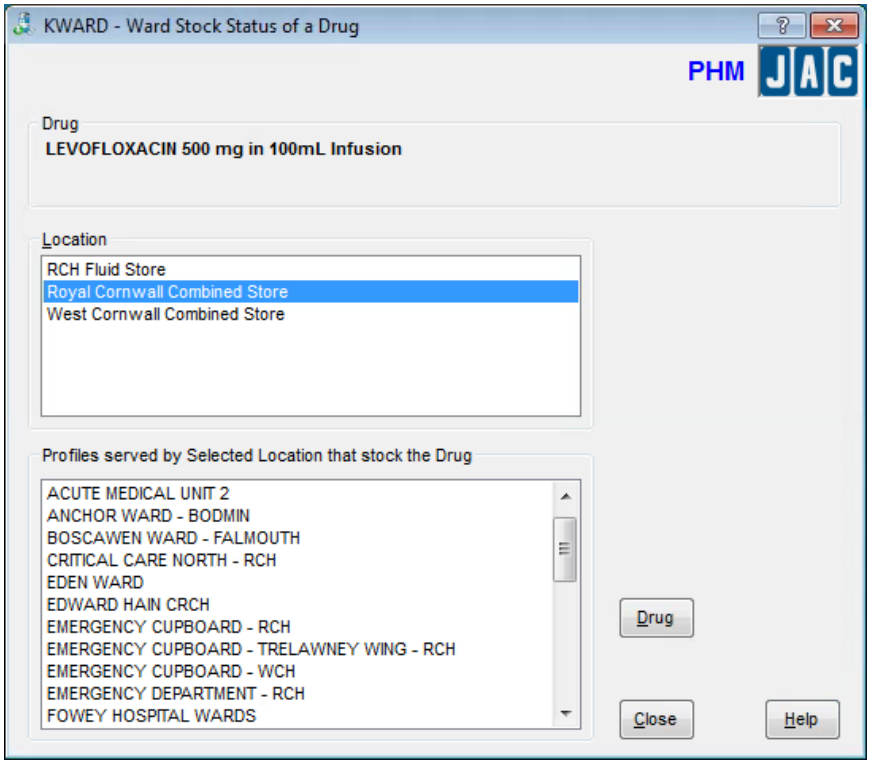
completed using the e-discharge process but on form CHA2592 then the white copy should be given to the patient, the blue copy filed in the designated location for pharmacy and the yellow copy filed in the patient's notes.

6.1.9. Accessing Medicines Out Of Hours

Pharmacy is open from 8.30am to 5pm 7 days a week. Please refer to the flow chart at the beginning of this chapter for an overview.

To locate medicines out of hours:

- log into the JAC KWARD programme
- enter the name of the drug you are looking for
- select the 'location' (if you are based at St Michael's or Treliske select Royal Cornwall Combined Store, for West Cornwall select West Cornwall Combined Store.
- A list of wards that stock that medicine will then be listed



- Contact the ward and ask if you can borrow the stock.

If the drug is listed as being stocked in the 'Emergency Cupboard' at RCH, this is located at the top of the ramp at Main Pharmacy. Access is available through the site co-ordinators. There is also an Emergency Cupboard in Trelawney Wing (near ED) and at WCH.

If you are still unable to locate the medicine and it is a critical medicine and a missed dose will have a significant impact on the patient, then contact the on-call pharmacist through switchboard. All calls will first be triaged by the site co-ordinator to ensure these initial steps have been explored.

6.1.10. Out of Hours Discharge Prescription (TTO) Process

6.1.10.1. Ideally, out of hours discharges should be anticipated and a discharge prescription written and dispensed in working hours.

6.1.10.2. The on-call pharmacist will not routinely dispense discharge prescriptions. Exceptional circumstances include a 'black' or 'OPEL 4' bed state or where there is a significant impact to the patient if they cannot be discharged with their medicines.

6.1.10.3. When it is necessary for an inpatient to be given medicine to take away from hospital premises and the pharmacy is closed, the doctor should prescribe the discharge prescription on EPMA as usual and print this off.

6.1.10.4. The nurse should check whether the patient has sufficient of his own medication and document this clearly on the discharge prescription so that duplicate items are not dispensed.

6.1.10.5. The nurse should refer to KWARD on JAC (see section 6.1.9.) which details which clinical areas stock the TTO pre-packs. Where possible, utilise these pre-packs following the process set out in section 6.1.8.

6.1.10.6. Where the patient requires a drug that is not available as a pre-pack but there is unlabelled stock of the drug on the ward, the Doctor/ nurse should access the emergency drug cupboards which contain a supply of empty containers and blank labels to allow the dispensing of items not held as pre-packs, using stock held on the ward.

6.1.10.7. The doctor/nurse will complete the label details on the pre-packs showing dose size, frequency, patient's name, ward name and date.

6.1.10.8. For drugs not available as pre-packs, dispense the minimum from ward stocks and complete the blank label with all the details above as well as the drug name and strength. The dispensing nurse/doctor should endorse the discharge prescription to indicate what has been dispensed; at this point the assembled prescription then needs to be checked by a second nurse or a doctor.

6.1.10.9. Controlled Drugs need to be issued by pharmacy, and therefore need to be dispensed by the on-call pharmacist.

6.1.10.10. The completed paperwork will then be filed in the designated location (as agreed with the ward pharmacist(s)) for collection and retrospective review. After collection the completed paperwork will be filed and stored in pharmacy department. If the TTO has not been completed using the e-discharge process but on form CHA2592 then the white copy should be given to the patient, the blue copy filed in the designated location for pharmacy and the yellow copy filed in the patient's notes.

6.1.11. Obtaining Medicines from Other Wards or Departments

Medicines can be 'borrowed' from other wards or departments when there is no stock available on the base ward. This should be tried before contacting the on-call pharmacist. Controlled drugs may never be "borrowed". However a *patient* may be administered a single dose of a controlled drug directly from any ward's stock. Please refer to the Controlled Drugs SOP available on the Document Library.

7. Dissemination and Implementation

7.1. This document will be hosted on the Trust's document library and significant changes to the policy will be communicated out via the pharmacy department and Medicines Practice Committee.

7.2. Training on this policy is within the medicines management mandatory and refresher training provided by the Trust and within bespoke training sessions for specific staff groups.

8. Monitoring compliance and effectiveness

Element to be monitored	Adherence to the Medicines Policy is covered by the general pharmacy audit plan which selects different elements of the policy to audit each year.
Lead	Iain Davidson - Chief Pharmacist.
Tool	The Pharmacy stock control system and Electronic Prescribing and Medicines Administration (EPMA) system records and departmental audits will be used to audit the access to medicines.
Frequency	Ongoing audit programme of the different elements of the Medicines Policy.
Reporting arrangements	Audits will be reported through to the Medication Practice Committee and the Pharmacy Governance Group as relevant.
Acting on recommendations and Lead(s)	The pharmacy team will lead on acting upon recommendations.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 2 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

9. Updating and Review

9.1. The policy documents will be reviewed no less than every three years and signed off through the Medication Practice Committee.

9.2. Revisions can be made ahead of the review date when the procedural

document requires updating. Where the revisions are significant and the overall policy is changed, the author will ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval will be sought from the Medical Director, and will be re-published accordingly without having gone through the full consultation and ratification process.

9.4. Any revision activity is recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is in Appendix 2.

Appendix 1. Governance Information

Document Title	The Medicines Policy Chapter 3: Ordering and Accessing Medicines V3.0			
Date Issued/Approved:	19th October 2018			
Date Valid From:	December 2018			
Date Valid To:	December 2021			
Directorate / Department responsible (author/owner):	Iain Davidson Chief Pharmacist			
Contact details:	01872-252593			
Brief summary of contents	Details of how to order and access medicines both in and out of hours			
Suggested Keywords:	Medicines, ordering, access, out of hours, discharge, TTO, drugs, medications			
Target Audience	RCHT	CFT	KCCG	
	✓			
Executive Director responsible for Policy:	Medical Director			
Date revised:	3rd October 2018			
This document replaces (exact title of previous version):	Replaces v2.2 of 'The Medicines Policy: Chapter 3 - Standards Of Practice - Ordering ward stock and non-stocks inpatient items'			
Approval route (names of committees)/consultation:	Pharmacy Governance Committee Medication Practice Committee Clinical Support Divisional Governance Committee			
Divisional Manager confirming approval processes	Karen Jarvill			
Name and Post Title of additional signatories	*'Not Required'*			
Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings	{Original Copy Signed}			
	Name: Kevin Wright			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	

Document Library Folder/Sub Folder	Pharmacy
Links to key external standards	CQC Medicines Optimisation standards (S4)
Related Documents:	Ward Guideline for Medicines Management Delayed and Omitted Doses of Medicines Policy Controlled Drug SOP Controlled Drug Policy Other Chapters of the Medicines policy
Training Need Identified?	Covered in the mandatory training and refresher updates for medicines management

Version Control Table

Date	Version No.	Summary of Changes	Changes Made By
31/03/11	1.0	Initial Issue	Iain Davidson Chief Pharmacist
10/06/11	1.1	Change format to match the Trust format and amend the dissemination and implementation and the monitoring and competency information.	Ian Davidson Chief Pharmacist
16/02/12	2.0	Amend in line with the new inpatient drug chart and opening of the Lloydspharmacy outpatient dispensary. Extra sections added related to transcribing, insulin passport and loading doses. Also included arrangements for non-registered staff to administer IV flushes and policy relating to mixing of medicines legislation. Included section on prescribing for yourself, families and other members of staff.	Iain Davidson chief Pharmacist and John Glinn Head of clinical Pharmacy Services.
28/01/15	2.1	Chapters 1-3 updated – (Chapter 1) changes to paragraph 5.3 (Role of prescriber) (Chapter 2) changes to paragraphs 6.1.4 (FP10HNCs), 6.1.8 (Prescribing for Yourself, Family Members and Members of Staff) (Chapter 3) Updated to include EPMA Chapters 4-7 remain as Version 2.0	Iain Davidson Chief Pharmacist
18/05/15	2.2	Chapters 3-4 updated to include a section on EPMA	Iain Davidson Chief Pharmacist
3/10/18	3	Overhaul of the chapter to include: • a flow chart, • update the out of hours dispensing policy • Include Pharmacy Ordering Portal	Iain Davidson Chief Pharmacist

		• A process for pre-pack dispensing and out of hours TTO dispensing	

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<tr><td colspan="6">Name of Name of the strategy / policy /proposal / service function to be assessed
The Medicines Policy Chapter 3: Ordering and Accessing Medicines V3.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Pharmacy</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Iain Davidson</td><td colspan="3">Telephone:
01872 252593</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">How staff order and access medicines for their patients</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">To allow for timely treatment of patients, avoid harm due to missed doses of medicines and promote patient flow</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">To deliver on its objectives</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">Missed dose rates of medicines
Out of hours calls to the on-call pharmacist</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Reduced patient harm, improved patient experience and improved patient flow.</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups

Pharmacy Governance Group
Medication Practice Committee</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">To update the existing chapter of the Medicine Policy to reflect current practice.</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		
Sex (male, female, trans-gender / gender reassignment)		**X**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

It doesn't meet the requirements for a full impact assessment

Signature of policy developer / lead manager / director	Date of completion and submission
	3/10/18

Names and signatures of members carrying out the Screening Assessment	1. Iain Davidson 2. Human Rights, Equality & Inclusion Lead	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust's web site.

Signed __ Iain Davidson_____

Date ____3/10/18_____