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Royal Cornwall Hospitals NHS Trust

The Medicines Policy
Chapter 4: Custody and Storage of Medicines

V4.0

May 2023

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. The safe custody and storage of medicines is an important element of being a safe and well-governed hospital. The Trust has a responsibility to ensure that all medicines administered to patients have been appropriately stored to guarantee their quality and efficacy.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. The policy sets out the requirements for the safe custody and storage of medicines within the Trust.

2.2. This policy incorporates the Royal Pharmaceutical Society's 'Professional Guidance on the Safe and Secure Handling of Medicines' (Jan 2019) and the Department of Health General design principles Version: 0.8.

3. Scope

3.1. The policy applies to areas not under the direct supervision of a pharmacy professional, e.g. hospital wards and other clinical areas, although the principles can be applied to any setting.

3.2. The principles also apply to RCHT activity that occurs off-site.

3.3. The policy will implemented by senior professional leads within the care groups e.g. ward and clinic managers and will affect all staff that work in an environment where medicines are utilised.

3.4. The safe storage of medical gas cylinders is covered in the 'Policy for Medical Gas Pipeline and Cylinder management'.

3.5. The safe storage and custody of controlled drugs is covered in the 'Controlled Drug Policy'.

4. Definitions / Glossary

A medicinal product is any substance or combination of substances that may be used by or administered to human beings with a view to restoring, correcting or modifying a physiological function by exerting a pharmacological, immunological or metabolic action, or making a medical diagnosis. Medicinal products come under the jurisdiction of the MHRA. Food, nutrition and herbal products are not classified as medicinal products.

5. Ownership and Responsibilities

5.1. Role of the Managers

5.1.1. The executive lead for medicines management is the Chief Medical Officer.

5.1.2. The chief pharmacist is responsible for ensuring the correct policies, processes and facilities are in place to enable good medicines management.

5.1.3. The Chief Nurse is responsible for ensuring that the nursing and AHP workforce are appropriately trained and managed on adherence to this policy.

5.1.4. The Director of Finance is responsible for ensuring the financial resource is available to ensure the necessary facilities are available to enable safe storage of medicines in line with our statutory requirements.

5.1.5. Line managers are responsible for ensuring staff are trained on safe custody and storage of medicines, that there is audit assurance of compliance and audit findings are acted upon.

5.2. Role of the Medicines Practice Committee

5.2.1. The Medicines Practice Committee is responsible for overseeing and providing assurance that this policy is correctly implemented and audited.

5.2.2. The Medication Safety Group will review datixes and audits relating to safe storage of medicines and ensure the learning is escalated to the MPC to inform policy development.

5.3. Role of Individual Staff

5.3.1. All staff are responsible for creating and maintaining a safe environment in respect of medicines and informing more senior staff of any relevant issues.

5.3.2. All staff involved in the use of medicines are responsible for understanding their obligations for safe custody and storage of medicines as set out in this policy and escalating concerns.

6. Standards and Practice

6.1. General Principles:

6.1.1. A risk management approach determines storage systems which reduce the risk of accidental access as well as unauthorised intentional access, whilst balancing the need for urgent or immediate access in clinical emergency situations.

6.1.2. Only registered healthcare professionals and members of the pharmacy department should have routine access to medicines within the Trust.

6.1.3. Designated portering staff that undertake deliveries of medicines should only have access to sealed delivery bags and should only be given access to treatment rooms under supervision for the purposes of delivering medications to a safe environment.

6.1.4. Any exceptions to these principles should be agreed with the chief pharmacist and ratified at the Medicines Practice Committee.

6.1.5. Medicines must always be stored out of direct sunlight and away from sources of heat (radiators etc.).

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

6.1.7. The governance principles for safe and secure handling of medicines – governance principles are:

- Establishing assurance arrangements.
- Ensuring capacity and capability.
- Seeking assurance.
- Continually improving.

6.2. Receiving Medicines:

6.2.1. Medicines will be supplied in locked or tamper-evident containers. Exceptions to this may occur during times of infectious disease outbreak e.g. norovirus and covid, where single use delivery containers may be required.

6.2.2. Deliveries should be opened as soon as possible by a designated Registered Healthcare Practitioner, and checked against the computer issues note and the original order.

6.2.3. The medicines should then be locked in the appropriate medicine cupboard or refrigerator as soon as possible.

6.2.4. Any discrepancy should be reported to pharmacy as soon as possible.

6.2.5. Should a delivery not arrive when expected, enquiries should be reported to pharmacy.

6.3. Storage of Medicines on the Ward, Operating Departments, Outpatient and Emergency Departments:

6.3.1. On the ward/ department the responsibility for the safekeeping of the medicines rests with the Ward or Department Manager.

6.3.2. The ward/department manager is responsible for controlling access (by keys or other means) to the medicine cupboards and trolleys. This responsibility remains even if he/she decides to delegate the duty of controlling access.

6.3.3. The ward or department manager is responsible for ensuring their clinical area has the appropriate equipment and facilities to ensure safe and secure storage or medicines.

6.3.4. Wards should comply with the NHS Protect ward guidance available on the NHS Protect website/ medicines security.

6.3.5. The basic premise is that all medicines should be stored securely in a lockable cupboard or storage unit.

6.3.6. Where these lockable cupboards are within a treatment room, the treatment room must have restricted access, ideally with a swipe-card but alternatively a keypad lock. The treatment room must be locked when not being accessed.

6.3.7. Ward sisters should regularly review the list of staff members that have access via the swipe-card. This list can be obtained from security and should be as restrictive as practically possible.

6.3.8. Where key pads are used on entry doors, the codes are changed at appropriate intervals subject to local risk assessment as deemed necessary to reduce the risk of inappropriate access.

6.3.9. Electronic locking systems that secure areas used to store medicines may use electronic keys, swipe cards or fingerprint and other technology that open the lock and lock immediately on closing the door. These systems allow cards or keys to be allocated to individual authorised persons, enabling audit of access to take place.

6.3.10. Standard keypads where a number is shared with multiple users are not suitable for medicine cupboards.

6.3.11. There should be distinct **lockable** storage facilities for:

- Controlled Drugs.
- Epidural and intrathecal infusions and other high-risk medicines.
- Oral solid medicines.
- Injectable medicines.
- Oral liquid medicines and rectal medicines.
- Medicines to take home.
- Flammable medicines.
- Medicines requiring refrigerated storage.
- External medicines and dressings.
- IV fluids (see 6.6).
- Patients' own medicines.

6.3.12. Drug cupboards to be used for internal and external medicines should comply with the current British Standard(s) 2881. Locks for cupboards (except patients' medicine cabinets/lockers) comply with the current British Standard as a minimum. The current British Standard is BS 3621.

6.3.13. Medicines with differing routes/methods of administration, or which look alike/sound alike should be stored separately or segregated to minimise selection errors.

6.3.14. Where there is perceived to be an extra risk, the advice of security specialists or Crime Prevention Officers, in consultation with the Chief Pharmacist, should be sought.

6.3.15. IV fluids must be stored in a locked cupboard or on an open shelf in a locked room. In specific circumstances it may be acceptable to maintain a 'working stock' of IV fluids that are not locked away. This must be subject to a local risk assessment. Working stock must be securely stored at the end of a work session.

6.3.16. All local anaesthetic infusions are stored separately from intravenous infusion solutions and other safe segregation practices are used, e.g. paediatric IV fluids, epidural preparations, glucose and perfusion fluids.

6.3.17. In theatres, when the theatre is not in use, or between operating sessions, all medicines should be returned to lockable medicine cupboards.

6.3.18. Medicine trolleys should be lockable and immobilised when not in use. The trolley must not be left unattended during the medicine round. If a practitioner using a trolley for a round has to leave it, it must be locked immediately.

6.3.19. When schemes for self-administration of medicines and/or 'one-stop dispensing' are in operation on the ward each patient involved in the scheme should have a lockable receptacle for medicines (e.g. drawer, individual cupboard), which is not readily portable.

6.3.20. All medicines with the exception of sublingual GTN, inhalers and topical creams/lotions, must be stored in a locked cupboard, in an environment that meets the manufacturers or pharmacy requirements. This includes the use of bedside lockers for medicines currently being taken by patients.

6.3.21. Non-medicines and chemicals such as disinfectants, diagnostic reagents (including those for urine testing), non-medicated dressings and dietary supplements, that may be accessed by people who would not otherwise have access to medicines should be stored separately from medicines.

6.3.22. Staff should be discouraged from producing their own ‘kits’ at ward level e.g. frequently used medicines, sepsis boxes etc as these have a habit of being stored inappropriately and therefore missing the standard expiry and safe custody checks. If a kit is required e.g. cardiac arrest kit, a formal request for this kit should be made to the Medicines Practice Committee who will consider its appropriateness, its storage and where these can be sourced from.

6.4. Storage and Access Arrangements of Medicines for Clinical Emergency

6.4.1. For clinical emergencies, e.g. cardiac arrest, all wards should have a source of urgent medicinal products. These should be held in boxes clearly marked "for emergency use". These boxes should be tamper-evident and should not be held in a locked cupboard, but at strategic and accessible sites.

6.4.2. These critical medicines should be in ready-to-administer preparations wherever possible.

6.4.3. Wards and clinical areas are responsible for ensuring that boxes or crash carts/trolleys for clinical emergencies are maintained. This includes replacing used items as soon as possible and checking and replacing expired or damaged items. This is the responsibility of the senior nurse or equivalent role to ensure these checks are being carried out.

6.4.4. Once a box has been opened, a request for a replacement should be made to pharmacy and the opened box returned to the pharmacy.

6.4.5. Where emergency bags or kits are held (e.g. for emergency teams working outside hospitals, or for major incidents), and it is impractical for these to be locked away they should be placed in an area that is most likely to have a constant staff presence. Neither the emergency kits themselves nor their contents should be obvious to the general public. These kits should be tamper-evident, and once a kit has been opened a replacement should be provided by the pharmacy and the opened kit returned to the pharmacy.

6.5. Medical Gas Cylinders

6.5.1. All medical gas cylinders should be securely stored in an approved holder or in a trolley chained to the wall.

6.5.2. Ward/ departments should keep minimal stock of medical as cylinders.

6.5.3. Patients must only be transferred with medical gas cylinders with the appropriate holders, the cylinder should never be placed on the bed next to the patient.

6.5.4. Areas where oxygen is stored or used must display appropriate signage. This is available from the Health and Safety or Pharmacy teams.

6.5.5. For full details on the safe storage of medical gas cylinders please refer to the medical gas cylinder policy on the documents library.

6.6. Storage of patients' own medicines

6.6.1. Patients may bring their current and/or old medicines with them on admission.

6.6.2. The level of security to be applied in the storage of patients' own drugs, including controlled drugs, and the way in which this is achieved, needs to be balanced against the need to ensure timely access to medicines when they are required e.g. anti-Parkinson's medicines.

6.6.3. Ideally all patients' own medicines should be handed over to the ward staff for safe custody in the bedside locker or other appropriate storage facility.

6.6.4. Where patients are not willing to give custody of the medicines to the ward staff, the medicines should be taken home to avoid the risk of medicines being administered without the knowledge of the team caring for the patient.

6.6.5. Patients taking abusable medicines that are dangerous in overdose should be warned of the risks involved in accessing an alternative supply of medicines whilst receiving the prescribed medicines within the hospital.

6.7. Custody of Medicine Locker and Medicine Cupboard Keys

6.7.1. The keys to cupboards containing medicines must be kept separately from all other keys. They must be kept on the person of an appropriate registered healthcare professional such as a nurse / midwife / ODP / pharmacist.

6.7.2. No other member of staff should have access to the keys, except the ward/ department Pharmacist/Pharmacy Technician or assistant, who needs access to the keys to regularly check the medicines' cupboards. Pharmacy staff must wear their Trust 'ID' badge to identify themselves, before keys can be handed over.

6.7.3. There should be local processes in place to ensure the custody of medicine cupboard keys is safe and appropriate throughout the nursing shift and at handover.

6.7.4. There is no maximum number of sets of drug keys that may be available to each nursing team. Much will depend on the type of ward/ clinical area. However, the number of keys should be closely controlled and kept to a minimum to reduce risk of loss and theft. As a guide, each nursing team should have no more than 2 sets of drug keys.

6.7.5. A spare set of keys may be kept in an appropriate, secure location. Wards and clinical areas are advised to provide pharmacy with a clearly labelled spare set of keys for use in emergencies.

6.7.6. At no point should medicine cupboard keys be left unattended. A Trust incident form should be completed in such instances.

6.7.7. Where keys go missing every effort must be made to find and retrieve them as a matter of urgency. The Appointed Nurse in Charge or equivalent must be informed and a Trust incident form completed. Where the medicine keys cannot be located, the locks must be changed as a matter of urgency. The Chief Pharmacist (or on-call pharmacist out of hours) and site manager must be informed.

6.7.8. In theatres, to ensure that medicines are readily available, the Appointed Nurse/ODP in Charge may delegate control of access to a qualified deputy or medical practitioner (e.g. anaesthetist) or to an Operating Department Practitioner (ODP) or, exceptionally, to an Operating Department Assistant (ODA).

6.8. Temperature Control and Storage of Medicines

6.8.1. Medicines must be stored under conditions that assure their quality until they are used or administered.

6.8.2. Any decision to use a medicine which has been stored outside the manufacturer's recommended temperature range must be done in collaboration with the ward pharmacist and/or the Medicines Information department (ext. 2587).

6.8.3. **Custody of Medication Requiring Refrigeration/ Freezing**

6.8.3.1. Medicine fridges and freezers should be maintained in good working order and kept locked when not in use.

6.8.3.2. Refrigerators and freezers should not be overloaded, to allow air circulation and medicines should not be stored in contact with the sides or bottom of the refrigerator/freezer.

6.8.3.3. The fridge or freezer must be defrosted regularly.

6.8.3.4. The fridge or freezer must not be used to store anything other than medicines.

6.8.3.5. Safeguards should be taken to ensure that refrigerators and freezers are not accidently switched off e.g. labelling the plug.

6.8.3.6. It is the Trust policy that fridge and freezer temperatures are monitored centrally by the Pharmacy department via a wireless monitoring system. Your ward/ clinic pharmacist needs to be notified of any new fridges/freezers so that they can place a probe within the equipment.

6.8.3.7. Wards and clinic areas are charged for the cost of the probe and an annual fee that covers calibration, monitoring and replacement.

6.8.3.8. The wards/ clinical area manager is responsible for ensuring that pharmacy have been notified and that central monitoring has been implemented. If this has not been set up then the senior nurse/ODP for the wards/ clinical areas is responsible for undertaking daily checks (or on the days when the clinical area is open) using a maximum/ minimum thermometer or data logger to ensure that medicines are being stored at the correct temperature and faulty fridges are detected. Please refer to appendix 4 of the 'Good Medicines Management' clinical guideline for a copy of the temperature log form.

6.8.3.9. With the central monitoring service, pharmacy will contact the senior nurse on the ward if the recorded temperature is out of range and they need to take action. Pharmacy will undertake an assessment of the medicines in the fridge/freezer to assess if they remain suitable for use or need to be discarded. Where maintenance works is required or a replacement fridge/freezer needed, this is the responsibility of the senior nurse/ODP for the wards/ clinical area to arrange and will come from the ward/clinical area budget.

6.8.3.10. For items that require refrigeration or freezing, the equipment used is designed for the storage of medicines and conforms to current guidance. Please ensure that any procurement is undertaken through the central procurement team and that a pharmaceutical grade fridge/freezer is purchased e.g. Labcold. Preferably new fridges should have a glass door that allows for easy identification of the fridge contents without having to open the door- thus maintaining better temperature control.

6.8.4. Ambient Temperature Control

Medicines that do not need fridge or freezer storage still require storage within a particular range. This can vary depending on the product e.g. less than 25^{o}C, between 15-25^{0}C etc. Pharmacy monitors all treatment rooms either with continuous monitoring using the wireless system or during peaks of temperature in winter and summer to validate the ambient storage temperatures are within range. Where they are not within range (and this is usually where temperatures exceed 25^{0}C), pharmacy will advise on what steps need to be taken to remedy the problem. Where temperatures consistently exceed 25^{0}C, air-conditioning will need to be installed. Where this is not possible, an arbitrary shortening of medicine shelf-life will be implemented based on the extent of the variation and type of product being stored.

6.9. Custody of Medicines after Death

6.9.1. All patient own medicines remain the personal effects of the patient. Although consent should be obtained from the patient's relatives to dispose of the medicines (following the Trust's disposal policy), it is illegal for members of the public to be in possession of prescription only medicines that have not been prescribed for them.

6.9.2. Where consent is not given, the healthcare professional must satisfy themselves that there are legitimate reasons for not consenting and that the medicines will not be used. Where the healthcare professional is not satisfied with the reasons, advice should be sought from the Chief Pharmacist.

6.9.3. All medicines provided for the patient by the hospital during their hospital stay remain the property of the hospital and can be destroyed or recycled as outlined in the pharmacy recycling and disposal procedures.

6.9.4. Where a death has occurred unexpectedly or is unexplained the medicines should be quarantined pending the case investigation and possible coroner's inquest. These should be returned to the pharmacy for safe custody via the chief pharmacist.

6.9.5. Where a death has occurred unexpectedly or is unexplained and a patient is routinely prescribed medicines that can be dangerous in overdose e.g. opioids or sedatives, consent should be sought from the relatives to check the patient's possessions to see if there and evidence that the patient may have been taking medicines without the knowledge of the ward staff.

6.9.6. Controlled drugs must never be returned to the patient's relatives. Contact the Trust's Controlled Drug Accountable Officer for further advice if required.

6.10. Drugs for Patient Escorts

6.10.1. Medical staff escorting a patient may obtain drugs by utilising medicines from the patient's ward or directly from the pharmacy as appropriate. The minimum number of ampoules or other dose-forms should be issued to the doctor by the patient's ward or department.

6.10.2. The medicines remain the responsibility of the doctor until either administered to the patient or returned to the point of issue.

6.10.3. Medicines that have been stored out of temperature range should be discarded via the appropriate waste disposal route, rather than returned into stock.

6.10.4. Doctors wishing to obtain escort drugs from pharmacy must present a signed order listing the drugs required and giving the patient's name and ward.

6.10.5. Any drug administered to the patient must be recorded on the inpatient prescription sheet or the case notes accompanying the patient.

6.11. Order Books and Stationery

6.11.1. The majority of medicine's orders are now placed electronically on the 'Pharmacy Ordering Portal'. However, hardcopies of order books and other stationery are still used in some areas and may be utilised as part of business continuity planning. All pharmacy requisition books and orders are controlled stationery to which only designated Registered Healthcare Practitioners should have access.

6.11.2. Pads of prescriptions (for outpatients, discharge, or FP10 variants) are also controlled stationery to which only doctors (or independent or supplementary prescribers in accordance with separate Trust policy) should have access. The loss of any controlled stationery must be reported immediately to the appropriate manager and to the Chief Pharmacist. Such loss is an 'incident' and shall be reported through Datix. Please refer to the Trust's Controlled Drug Policy for more information.

6.12. Products That Require Special Considerations

Examples include, but are not limited to:

6.12.1. Potassium chloride concentrate solutions

6.12.1.1. Potassium chloride concentrate solutions are restricted to pharmacy departments and to those critical care areas where the concentrated solutions are needed for urgent use.

6.12.1.2. Potassium chloride concentrate and other strong potassium solutions are not to be held as routine stock in wards and clinical departments.

6.12.1.3. Potassium chloride concentrate solutions should be ordered as a Controlled Drug and stored in a controlled drug cupboard.

6.12.1.4. Potassium chloride concentrate solutions should not be transferred between clinical areas. All supplies should be made directly from the pharmacy department.

6.12.1.5. Commercially prepared ready to use diluted solutions containing potassium should be used wherever possible (including critical care areas).

6.12.2. High strength opiates

6.12.2.1. Packaging of different strengths of diamorphine and morphine ampoules look the same; the outer carton and ampoule labelling are poorly differentiated; and 5mg, 10mg, 15mg, 20mg and 30mg products have similar appearances. Ward and clinical areas should minimise the range of products stocked in their areas to reduce the risk of medication error and patient harm.

6.12.2.2. High strength products are restricted to critical care areas and areas that routinely use syringe drivers.

6.12.2.3. High dose morphine and diamorphine should be stored using separate shelves or other means of segregation.

6.12.2.4. Please refer to the Controlled Drug Policy and ward SOP for more detail.

6.12.3. Epidurals

Reduce the risk of the wrong medicine being selected by storing epidural infusions in separate cupboards or refrigerators from those holding intravenous and other types of infusions.

6.12.4. Midazolam

6.12.4.1. The storage and use of high strength midazolam (5mg/ml in 2ml and 10 ml ampoules; or 2mg/ml in 5ml ampoules) is restricted to general anaesthesia, intensive care, palliative medicine and clinical areas/situations where its use has been formally risk assessed, for example, where syringe drivers are routinely used.

6.12.4.2. The reversal agent, flumazenil, must be stocked and available where midazolam is used.

7. Dissemination and Implementation

7.1. The document will be available on the document library

7.2. Training on the policy is part of the mandatory induction and update training as well as part of local induction.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Safe storage of medicines
Lead	Pharmacy and ward/clinical area sisters
Tool	Quanta audit tool. Ward accreditation. Annual pharmacy safe storage audit.
Frequency	Monthly for Quanta. Annually for pharmacy audit.

Information Category	Detail of process and methodology for monitoring compliance
Reporting arrangements	Results will be reported to the Medication safety Grp and the Medicines Practice Committee and disseminated from there as appropriate.
Acting on recommendations and Lead(s)	The Medicines Practice Committee will lead on ensuring audit. actions are followed up. The medication safety pharmacist, medicines optimisation clinical nurse specialist and senior nurses/ODPs will act on recommendations as appropriate to their areas.
Change in practice and lessons to be shared	Via the Pharmacy Newsletter (Pharmacy Matters) and through safety huddles and safety briefs.

9. Updating and Review

This policy will be reviewed through the Medicines Practice Committee no less than every three years or shorter is guidance changes in that time.

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 And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	The Medicines Policy Chapter 4: Custody and Storage of Medicines V4.0
This document replaces (exact title of previous version):	The Medicines Policy Chapter 4: Custody and Storage of Medicines V3.0
Date Issued / Approved:	May 2023
Date Valid From:	May 2023
Date Valid To:	May 2026
Author / Owner:	Iain Davidson, Chief Pharmacist
Contact details:	01872 252593
Brief summary of contents:	Outlines the standards for the safe custody and storage of medicines at RCHT.
Suggested Keywords:	Medicines, drugs, storage, custody
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Medicines Practice Committee. Clinical Support Governance Group.
Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming consultation and ratification:	Kevin Wright
Links to key external standards:	CQC Royal Pharmaceutical Society Hospital Pharmacy Standards

Information Category	Detailed Information
Related Documents:	The Medicines Policy. RCH and RPS- Professional Guidance on the Administration of Medicines in Healthcare Settings Jan 19 Humans Medicines Regulations 2012 RPS- Professional guidance on the safe and secure handling of medicines. Dec 18. Clinical Guidelines for good medicines management on wards/ clinical areas.
Training Need Identified:	Yes- included as mandatory training for induction and refresher.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pharmacy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2011	V1.0	Moved from paper-based book to on-line medicines policy. Initial issue	Iain Davidson Chief Pharmacist
March 2013	V1.2	Review	Iain Davidson Chief Pharmacist
March 2016	V2.0	Full Review	Iain Davidson Chief Pharmacist
March 2019	V3.0	Incorporate changes in the Royal Pharmaceutical Guidelines for safe storage published in Dec 18 Learning from Serious Incident regards patient's own medicines Temp control to include information on the central monitoring service Section medicines requiring special consideration	Iain Davidson Chief Pharmacist

Date	Version Number	Summary of Changes	Changes Made by
May 2023	V4	Delivery arrangement if infection control issues. Comment about discouraging 'kits' being made up on wards without involvement from MPC.	Iain Davidson Chief Pharmacist

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

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

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

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	The Medicines Policy Chapter 4: Custody and Storage of Medicines V4.0
Department and Service Area:	Pharmacy, Clinical Support
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Iain Davidson, Chief Pharmacist
Contact details:	01872 252593

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Safe storage and use of medicines at RCHT
2. Policy Objectives	Patient safety and minimising patient harm
3. Policy Intended Outcomes	Outlines the standards for the safe custody and storage of medicines at RCHT.
4. How will you measure each outcome?	Audit
5. Who is intended to benefit from the policy?	Patients and the organisation

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Medicines practice committee Clinical Support Care Group
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Iain Davidson, Chief Pharmacist.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis