Royal Cornwall Hospitals
NHS Trust

The Medicines Policy - Chapter 6: Standards of Practice Discharge and Miscellaneous

V4.0

September 2023

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

The Trust has a duty under the Data Protection Act 2018 and UK 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 UK 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 UK 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. This policy sets out the processes that should be followed by RCHT staff when discharging patients from the Trust. It includes the requirements both for discharge to home and to other healthcare and social care institutions.

1.2. The policy also covers other miscellaneous elements of Medicines Policy at RCHT.

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

2. Purpose of this Policy/Procedure

To ensure that medicines are prepared and administered to our patients safely, legally, and effectively by RCHT staff.

3. Scope

This policy applies to all staff that are involved in the prescribing, administration, and preparation of medicines at RCHT.

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

- The executive lead for medicines management is the Medical Director.
- The chief pharmacist is responsible for ensuring the correct policies, processes and facilities are in place to enable good medicines management.
- The Director of Nursing and AHPs is responsible for ensuring that the nursing and AHP workforce are appropriately trained and managed on adherence to this policy.
- The Director of Finance is responsible for ensuring the financial resource is available to ensure the necessary facilities are available to enable safe preparation and administration of medicines in line with our statutory requirements.
- Line managers are responsible for ensuring staff are trained on safe preparation and administration of medicines, that there is audit assurance of compliance and audit findings are acted upon.

5.2. Role of the Medicines Practice Committee

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

- The Medication Safety Group will review Datix's 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

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

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

6. Standards and Practice

6.1. Patients Moving Between Healthcare Trusts

6.1.1 Transfer of Patients to Hospitals and Hospices in Cornwall

- Where discharging a patient to a community hospital or hospice the patient should be prescribed all their medicines on the discharge summary but only the medicines not stocked on the receiving ward should be supplied.

- When sending a discharge prescription (TTA) for a patient to pharmacy, the destination and time of transport (if known) should be added so that the pharmacy department can ensure that an appropriate supply of medicines is made in a timely manner.

- When completing the electronic TTA for the patient the prescriber should also, where possible, adjust the inpatient drug chart to match what medications the patient should take after their transfer to the community hospital or hospice e.g. IV to oral antibiotics. Community hospitals and hospices will us the existing drug chart on ePMA to administer medicines rather than the discharge summary.

- CFT and Hospices are now on the same ePMA system as RCHT and therefore their drug chart will remain current when they move organisations.

- A copy of the electronic discharge which will give information about the patient's inpatient treatment and ongoing therapy requirements as well as the medicines that the patient should continue on discharge/transfer.

6.1.2 **Transfer of Patients to Secondary Care Outside Cornwall**

The patient should be discharged with the following documents:

- Medication Administration Profile (MAP) from the JAC EPMA system which gives the history of medication administrations during the inpatient stay.

- Medicines Administration Chart (MAC) from the JAC EPMA system which the receiving unit will administer from until it is re-written onto an appropriate prescription chart by a doctor.

It may be appropriate to discharge the patient with a supply of medicines, but this will depend on the circumstances of the transfer and should be discussed with the ward pharmacist on a case-by-case basis.

6.1.3 **Discharging Patients and Discharge Prescriptions**

- For the correct procedure for discharging patients with discharge prescriptions (TTAs) please refer to the Clinical Guideline for Ward Medicines Management in the documents library.

6.2. **Unlicensed medicines**

6.2.1. This term is usually applied to those medicines which do not have a Marketing Authorisation (more commonly known as product licence) or when licensed medicines are used for unlicensed indications. For example many medicines used to treat children only have licensed indications for use in adults.

6.2.2. For good clinical reasons the use of unlicensed medicines and the use of licensed medicines for unlicensed indications is not uncommon in hospitals. There are risks, however, and medical and nursing staff need to be aware of these and take precautions to minimise them.

6.2.3. If a prescriber uses an unlicensed medicine or a medicine for an unlicensed indication, they do so on their own responsibility. Consequently they carry the burden of the patient's welfare and in the event of an adverse reaction or under clinical governance arrangements he/she may be called upon to justify their action.

6.2.4. To minimise the risk the following steps should be followed:

- Ensure there is no licensed alternative available.

- Initial requests to use an unlicensed medicine must be made by completing a 'Formulary Request' form (available from the Pharmacy) and approved by the Cornwall Area Prescribing Committee.

- Initial prescribing/ recommendation must be undertaken by a consultant.

- The prescriber must ensure that the unlicensed use meets Bolam principles i.e. that the practice is supported by a respectable body of medical opinion, is logical and not outdated. 'Respectable body of medical opinion' includes reputable journal articles and peer consensus guidelines.

- The prescriber must advise nursing staff and make them aware. As independent practitioners they may wish to be provided with more detailed information concerning the treatment and medicine.

- The patient should be informed of the unlicensed status of the medicine and discuss the risks and benefits (as per the Montgomery principle).

- GPs may be reluctant to take prescribing responsibility. The prescriber is responsible for keeping the GP properly informed and for providing them with all the information to allow them to make an informed decision.

6.3. **Monitored Dose Systems**

Patients may require monitored Dose Systems to support compliance. These should only be introduced as a reasonable adjustment to meet a patient's need, rather than at the request of a blanket policy by a domiciliary care agency or therapist. It is the pharmacist that has the legal duty to make a reasonable adjustment and therefore it should be the pharmacist undertaking the assessment of whether one is required.

Hospital staff may administer medicines to patients from MDS's if they can assure themselves of the identity and quality of the medicine. In most instances, a new supply would be requested, rather than using the MDS, but there are occasions, such as admissions out of hours, where it might be in the patient's best interests to utilise the MDS medicines e.g. a time critical Parkinson's medicine.

6.3.1. Tamper Evident (Blister Packs)

- Some patients in the community have their medications dispensed into tamper- evident packs, known as monitored dose systems (MDS) containing each daily dose of the majority of their solid-dose medications, in order to aid their compliance and give a visual indication of whether doses have been taken. For continuity of device and supply these packs need to be ordered via the patient's usual community pharmacy, however they generally require 48 hours' notice which is not always possible.

- When this is not possible, the outpatient pharmacy (Lloyd's pharmacy at the time of writing) can undertake a limited number of MDS on a daily basis with a turnaround time of 4 hours.

- If a blister pack cannot be arranged via the community pharmacy or Lloyds in time for discharge, a 14-day blister pack can be supplied from the RCH pharmacy if sufficient notice is given.

- Ward staff must inform their ward pharmacist or medicines management technician when a patient is admitted on an MDS so that they can undertake an assessment of the patient and start planning for discharge.

- Ward staff must advise pharmacy staff immediately when discharge is being planned – if there has been any change in medication, at least 24 hours' notice is needed to arrange for new packs to be produced.

- If a monitored dose system is considered necessary for a new patient, the ward pharmacy team should undertake a compliance aid assessment. MDS's are only used when deemed as a 'reasonable adjustment' to assist the patient due to a disability of some kind. Implementing an MDS to meet the needs of a domiciliary care agency rather than the patient should be challenged. Other compliance aids, such as medicines reminder charts, may be more appropriate.

- When starting a new patient, liaise with the patient's regular community pharmacist who may conduct their own assessment after discharge of the suitability of the patient and their medication before agreeing to fill the monitored dosing device.

- For established patients that use compliance aid devices that we do not support within the hospital (e.g. PIVOTAL), this is referred back to their community pharmacist.

6.3.2. Non-Tamper Evident (Refillable Devices)

- Some patients use refillable, non-tamper evident, compliance aids which contain compartments for the daily doses of the majority of their solid dose medications. These usually contain enough medications for a day or a week and may be refilled by the patient, the patient's family, or a carer.

- These devices must not be filled by hospital staff and must only be used by patient's family or carers where a blister pack provision in the community is awaited

6.4. Paraffin Containing Products

The MHRA drug safety updates have advised all healthcare staff involved in the prescribing, dispensing or administration of paraffin-based skin products of a potential fire hazard. Bandages, dressings, and clothing in contact with paraffin-based products for example white soft paraffin, yellow soft paraffin, emulsifying ointment, and white soft paraffin 50% liquid paraffin are easily ignited with a naked flame or cigarette.

- If a patient insists on leaving the ward to smoke, they should be told of the risk and advised to wear a thick outer coat free of paraffin-containing products.

- The patient/family should be advised to change any clothing or bedding which becomes impregnated with paraffin products.

- The nurse should record that this advice has been given on the first occasion.

- Fire safety notices should be prominently displayed in areas where paraffin-containing products are frequently used.

- More details can be found on the National Patient Safety Agency website.

6.5. **Home Delivery of Medicines**

The Trust supports a number of home delivery arrangements for selected medicines. Each homecare provider company must undergo the appropriate 'bona fide' checks by the pharmacy department and an appropriate SLA and contract monitoring arrangements agreed before the company can begin to deliver a service. Under no circumstances should a prescriber initiate a new home delivery arrangement without authorisation from the pharmacy department. Please refer to the Trust's Homecare Medicines Policy.

6.6. **Loading doses**

6.3.3. A loading dose is an initial large dose of a medicine used to ensure a quick therapeutic response. It is usually given for a short period before therapy continues with a lower maintenance dose. The use of loading doses of medicines can be complex and error prone. Incorrect use of loading doses or subsequent maintenance regimens may lead to severe harm or death. (NPSA RRR018 - Preventing fatalities from medication loading doses).

6.3.4. To help medical, nursing and pharmacy staff prescribe, check the doses, and administer these medicines safely, loading dose worksheets have been developed. The loading dose worksheets contain information on dosage, follow up prescriptions, administration and any monitoring that is necessary. They can be accessed electronically via the intranet (in the Pharmacy folder of the Document Library). Loading dose worksheets are available for the following medicines which were judged to be the highest risk and therefore more prone to error:

- Acetylcysteine.

- Aminophylline.

- Amiodarone (IV and oral).

- Argatroban.

- Bivalirudin.

- Danaparoid.

- Digoxin (IV and oral).

- Eptifibatide.

- Phenindione.
- Phenytoin.
- Tirofiban.

6.7. Collection of Prescription Charges

6.7.1. All patients, unless exempt, should pay a prescription charge for each item they receive on an outpatient prescription.

6.7.2. Patients can also be charged the prescription charge for medicines supplied from day-case units and the Emergency Department.

6.8. Medical/ Drug Representatives

Please refer to the Trust Policy on Representatives. Important aspects relating to medicines are:

- Providing samples of medicinal products for use on Trust patients is prohibited. Any offer of free stock for formulary medicines must be agreed with the pharmacy procurement department.
- The price RCHT pays for any drug or usage figures must not be divulged to anyone outside the Trust without the Chief Pharmacist's permission. This information is commercially sensitive, and disclosure may compromise the Trust's contract prices.

6.9. Parenteral Nutrition

6.9.1. All requests for all adult, neonatal and paediatric patients to receive Parenteral Nutrition should be in line with the Trust's parental nutrition policies for these patient groups.

6.9.2. Completed TPN is placed in the refrigerator at the top of the Pharmacy slope by 17:50 hrs each evening for collection by the ward when needed.

6.9.3. The initiation of TPN is not considered an emergency out of hours; however, any clinical enquiries out of hours should be channelled initially to the on-call pharmacist.

6.4. Adverse reactions, near misses, incidents and risks in prescribing, administration, and custody of drugs

- The Trust believes in an open and fair culture when reporting incidents and risks to ensure that patient safety is not compromised. All staff should be encouraged to log incidents on Datix and complete risk assessments when incidents, near misses or risks are identified.
- All incidents regarding medicines are reviewed by the pharmacy team and actions implemented to reduce the risk of recurrence. The medication safety officer (MSO) leads on these reviews.

- Incidents must also be reported to the most senior nurse/midwife/ODP on the ward/ clinic area as soon as possible, who will liaise with the Ward Manager/Matron for that area, as well as with appropriate medical and pharmacy staff.

- Allergic reactions to drugs should be reported and documented in line with the Procedure for Allergies or Idiosyncrasies to Medicines. Suspected adverse drug reactions should be reported to the MHRA via the yellow card system- please refer to the back of the BNF or the on-line reporting tool.

- Where a risk has been identified concerning medicines then a Trust risk assessment form should be completed, and the risk logged on the risk register. This will usually be co-ordinate through the governance/risk lead for the service and high risks will require approval at Care Group level before escalating further. An action plan will need to be put in place to remove or mitigate the risk.

6.10. Reference sources to assist with prescribing and administration

- It is important that all staff involved with prescribing and administration have access to up-to-date medicines information and clinical reference sources.

- There is a wealth of information available on the internet e.g. NHS evidence, the map of medicine and the NELM. Please note that Trust policies and procedures may differ from advice given on the internet. Trust polices should always take precedent.

6.10.1. Common reference sources used in the Trust are:

- British National Formulary and BNF for Children (shortcuts can be downloaded from the Trust's App catalogue).

- www.medicines.org.uk - for patient information leaflets and summary of Product Characteristics.

- Medusa Injectables Guide (shortcuts can be downloaded from the Trust's App catalogue) or via- http://medusa.wales.nhs.uk/

6.10.2. The Cornwall and Isles of Scilly Formulary **- details which drugs can be used, restrictions around their use and other supplementary information.**

https://www.eclipsesolutions.org/Cornwall/info.aspx?paraid=50

6.10.3. Trust policies **- available on the document library**

Advice can also be sought from the ward pharmacist or from **Medicines Information** on Extension Number 2587.

6.11. Using Patients' Own Medicines

- Medicines brought into hospital are the property of the patient. They may, with the patient's permission or the permission of their carer, continue to be used provided they have been prescribed on a hospital prescription and they have been examined and approved in accordance with the standards set out below.

- When a medicine brought in by a patient is not to be used again or is not found to be suitable for use and with the agreement of the patient or their carer it should be sent to pharmacy for disposal.

- When a medicine which is brought in by the patient will not be administered while the patient is in hospital but will be used after discharging it should be stored securely on the ward for return to the patient on discharge.

- Patients' medicines that have been prescribed and approved for use must be stored in the patient's own locked medicines cabinet on the ward or where there is no such cupboard, in the ward drug trolley.

- The ward manager is responsible for ensuring that a patient's own medicines remain with the patient at all times when they are moved within the hospital.

Before a patient's own medicines can be administered in hospital they must be checked by a nurse, pharmacist, or pharmacy technician to ensure that:

- The medicines are clearly labelled with:
    - The name of the patient.
    - The name and strength of the medicine.
    - Method and frequency of administration.
    - Date dispensed (do not use if dispensed more than six months ago).
    - Name and address of the supplier (pharmacy).
- The directions on the label match those on the inpatient prescription chart. The doctor or pharmacist must be alerted if the label does not match the prescription chart.
- If the medicine has no dispensing label, it must not be used unless:
    - The identity of the medicine is beyond doubt.
    - The batch number and expiry date of the medicine can be read.
- Confirmation is required that the medicines have been stored appropriately, e.g., in a refrigerator.
- The overall appearance of the bottle, label and medicine must be acceptable.

- At discharge the patient's own medicines together with additional hospital medicines stored in the patient's medicines cabinet must be checked against the discharge prescription by the pharmacist or doctor before being handed to the patient.

6.12. Retention of Records

- Drug and controlled drug requisition books and registers must be stored on the ward for two years after the date of last entry. Prescription sheets and continuation sheets should be filed in the patient's notes.

- Copies of drug issue paperwork and pharmacy ordering portal-controlled drug paperwork do not need to be retained as the necessary details are available on the electronic systems and within the Controlled Drug registers.

- Guidance on retention of pharmacy documentation such as enquiries and batch documentation can be found in the pharmacy records policy.

6.13. Ward Moves or Closures

- The pharmacy must be contacted in advance of any permanent or temporary ward closures or location transfer.

- Separate arrangements exist for Controlled drugs, see the relevant Trust Policy.

- For short-term closure (not exceeding 7 days) the pharmacy will conduct a risk assessment before deciding whether to remove stock. The risk assessment will be conducted with the assistance of the security advisor.

- Other medicines may be moved by any member of the team under the supervision of an appointed member of pharmacy staff.

6.14. Defective or Suspected Falsified Medicines

- If any medicine is suspected of being defective or falsified, the medicine should not be administered. It should be isolated, retained, reported, and returned to Pharmacy for quarantine and further investigation as set out in the Pharmacy procedures.

6.15. Other Matters

Medicine Labels

- Medicine labels must NOT be amended by hand. If necessary, the medicine should be returned to the pharmacy team for re-labelling.

- Any medicine being given to a patient to take away with them must be appropriately labelled to meet the legal requirements of supply of medicinal products.

6.16. Transfer/Decanting of Medicines between Containers

Medicines must not be transferred from one storage container to another. For example- staff should not transfer 3 part-packs of one product into a single box or decant a bag of normal saline into a container to be used for saline flushes.

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	All elements of the chapter of this policy.
Lead	Pharmacy and ward/clinical area sisters.
Tool	Ward accreditation, incident reporting, auditing of specific processes such as intrathecal on a Word or Excel template specific to the topic.
Frequency	On a rolling basis as part of incident reporting and clinical audit plans.
Reporting arrangements	Results will be reported to the Medication Safety Group 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

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

9.2. Any revision activity will be 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 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 6: Standards of Practice Discharge and Miscellaneous V4.0
This document replaces (exact title of previous version):	The Medicines Policy Chapter 6: Standards of Practice Miscellaneous and Discharge V3.0
Date Issued / Approved:	Friday 15 September 2023
Date Valid From:	September 2023
Date Valid To:	September 2026
Author / Owner:	Iain Davidson, Chief Pharmacist.
Contact details:	01872 252593
Brief summary of contents:	Outlines the standards for the safe discharge and other miscellaneous topics relating to the safe use of medicines at RCHT.
Suggested Keywords:	Medicines, drugs, discharge, compliance, MDS, patients own, records, transfer
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. 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. CFT Covert Administration of Medicines Guideline.
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	Full Review	Iain Davidson, Chief Pharmacist
January 17	V2.1	Revision of the discharge content	Iain Davidson, Chief Pharmacist
March 2020	V3.0	Full review into new format	Iain Davidson, Chief Pharmacist
August 2023	V4.0	Full review with minor changes including the implementation of ePMA into CFT and the hospices	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 6: Standards of Practice Discharge and Miscellaneous 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 discharge of medicines and other miscellaneous matters at RCHT
2. Policy Objectives	Patient safety and minimising patient harm
3. Policy Intended Outcomes	Reduction in patient harm and improved patient flow.
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: Yes • 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	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
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