Royal Cornwall Hospitals
NHS Trust

Good Medicines Management Clinical Guideline

V6.0

September 2025

Table of Contents

1. Aim/Purpose of this Guideline 3
2. The Guidance 3
2.1. Stock, non-stock and patient's own drugs 3
2.2. Safe Storage of Medicines 5
2.3. Transfer of Patients and their Medicines between Wards and at Discharge 5
2.4. Discharge Prescriptions (TTOs) 6
2.5. Expiry Date Management 7
3. Monitoring compliance and effectiveness 8
4. Equality and Diversity 9
Appendix 1 Governance Information 10
Appendix 2 Initial Equality Impact Assessment 13

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. Aim/Purpose of this Guideline

1.1. This guideline applies to all staff that are involved with medicines on a day-to-day basis on the wards and in clinical areas.

1.2. The guideline sets out the practical aspects of how medicines should be handled on the ward/ clinical area, on transfer and on discharge.

1.3. The guideline aims to ensure there is a consistent approach to medicines management across all wards and clinical areas to minimise the risk of missed doses and to reduce waste.

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

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2. The Guidance

2.1. Stock, non-stock and patient's own drugs

2.1.1. Stock Drugs

- Each ward/ clinical area has designated stock drugs.
- These drugs are stored in the treatment room cupboards and drugs trolley.
- Each area is provided with a stock list that staff should refer to if they are unsure of what is stocked in their area.
- Each ward receives a minimum of a weekly ward stock top-up service from pharmacy.
- Non-ward clinical areas are generally not on top-up and place stock requests as required with the pharmacy department.

- To order ward stock outside of the top-up service, use the electronic Pharmacy Ordering Portal (POP) or order in the A4 ward stock book (CHA49) if POP is not available.

- The stock list should be reviewed on a periodic basis with the ward sister and ward pharmacy team to ensure the list remains appropriate for the clinical area. This helps to reduce wastage and missed doses of medicines.

2.1.2. Non-Stocks

- Non-stocks are those drugs that are not stocked by the ward/ clinical area.

- Non-stocks are supplied on a named patient basis and will generally be labelled with directions to allow them to be used on discharge.

- Ideally patient's own drugs (PODs) should be utilised for existing medicines the patient was taking on admission and only new medicines ordered as a non-stock. This is to help reduce wastage, dispensary demand and environmental impact.

- Non-stock drugs should be stored in the patient's bedside locker where available. The exception to this would be controlled drugs.

- Non-stock drugs must be ordered using the Pharmacy Ordering Portal (POP).

- If the non-stock drug is urgent please indicate this on the POP order.

- When POP is not available, non-stocks should be ordered using the paper non-stock request form; these will be circulated by pharmacy as part of their business continuity plans.

- Please be aware of the missed and delayed dose policy available on the document library and make yourself familiar with those medicines deemed 'critical medicines', where a missed or delayed dose can quickly lead to patient harm. Most critical medicines are available in the 'emergency drugs cupboard', accessed via the site co-ordinators out of hours.

2.1.3. Patient's Own Drugs

- Patient's Own Drugs (PODs) are those drugs brought in by the patient on admission.

- PODs should be utilised to dose patients during their admission once they have been assessed as suitable to use.

- PODs should be used in preference to ordering a new supply for medicines the patient has been taking before admission. Only when the POD supply is coming to an end, should a non-stock resupply be ordered.

- PODs are patient's property and therefore verbal consent must be given before they are used. They must not be used for other patients.
- Where a POD has been stopped on admission, permission should be given by the patient before disposing of the medicine. If the patient refuses to give permission, the drug should be placed in a bag in their locker and a label added to say 'do not use'.
- PODs must be stored in the patient bedside locker where available.
- The ward pharmacist/ technician/pharmacy assistant, the ward nurse or doctor can assess the PODs for suitability of use. Please check:
  - The packaging is intact and expiry date has not been passed.
  - The label is clearly readable and contains the following information:
    - Name and strength of medication.
    - Dose and frequency.
    - Patients name.
    - Date dispensed (must be within the last 6 months).
    - Name and address of dispensing chemist or doctor.

2.2. Safe Storage of Medicines

2.2.1. Detailed guidance on safe storage of medicines can be found in the Medicines Policy.

2.2.2. As a general rule, all medicines (including patients' own medicines) must be locked away. The general exceptions to this are inhalers, eye drops, GTN sprays and creams that can be stored at the patient bedside.

2.2.3. It may also be appropriate for other 'Time-critical medicines' to be stored at the patient bedside but in an unlocked container. Please refer to the self-administration policy for further information.

2.3. Transfer of Patients and their Medicines between Wards and at Discharge

2.3.1. All non-stock medicines and patient's own drugs (PODs) should be moved with the patient when they are transferred to another ward using the green bags provided.



2.3.2. Failure to do this increases the risk of patient harm through missed doses, and results in unnecessary waste.

2.3.3. On discharge, the ward pharmacy team or nursing team should clearly annotate on the discharge prescription sent to pharmacy, which medicines need to be dispensed and which the patient already has. Generally only newly initiated medicines should be supplied on hospital as the patient will already have a supply of existing medicines through their community pharmacy or GP practice.

2.3.4. If necessary, all non-stocks medicines and PODs can be sent down to pharmacy with the discharge prescription, using the green bags provided, to allow the dispensary team to assess which medicines are required to supply on discharge.

2.3.5. For patients being transferred to a community hospital or hospice a discharge prescription is still required. RCHT pharmacy will provide all medicines for the patient other than items that are stocked on the receiving ward e.g. paracetamol and enoxaparin or that the patient already has as a POD.

2.4. Discharge Prescriptions (TTOs)

2.4.1. The ward pharmacist or technician should be contacted when a TTO is required.

2.4.2. Where the ward pharmacist is not available, **send the TTO and any drugs in the bedside locker** down to pharmacy.

2.4.3. Please indicate on the TTO the expected discharge time of the patient and to where the patient is being discharged e.g. home, care home, community hospital, hospice. The destination is important as this may alter what medicines the pharmacy will supply.

2.4.4. TTO progress in pharmacy can be tracked by logging onto the TTO tracking system:

2.4.4.1. If not available as a shortcut on the desktop, then go to the Trust Intranet page.

2.4.4.2. The link is available on the homepage or click on ‘A-Z resources’.

2.4.4.3. Click on ‘TTO tracking’.

2.4.4.4. Click on ‘all wards’ and filter for your ward.

2.4.4.5. Enter your ward username and password (if unknown contact pharmacy).

2.4.4.6. You will then be able to see what stage the TTO is at in the process. Pharmacy aims to process all TTOs within 2 hours.

2.4.5. A minimum of 14 days' worth must be supplied on discharge, with the exception of medicines required for a specific course length or when required medicines.

2.4.6. When a patient has sufficient supply of a medicine at home and there has been no change to the doses during the admission, no further supply will be given on discharge. The TTO print out sent up with the patient's drugs will state 'patient's own'.

2.4.7. The nurse should always do a final check of the drugs supplied against the most up to date version of the TTO to ensure no last minute changes have been made and that all the required drugs have been supplied and that all medicines (including controlled drugs and fridge items), have been added to the bag. This is an important final safety check. **Nurses are strongly recommended to utilise the TTO reminder check-list** that is attached to the outside of every TTO bag to prompt the necessary steps to ensure a safe medicines discharge.

2.4.8. The nurse needs to ensure that patients are not sent home with medicines that have been discontinued or any stock medicines or other patients' medicines that might be in the patient's bedside locker. If a patient's own medication (i.e. medicines the patient has brought in with them from home) has been stopped, permission should be given from the patient to remove and dispose of those medicines. If permission is not given, the medicines can be returned to the patient with clear instructions that the medicines are no longer prescribed.

2.4.9. The nurse should go through the medicines with the patient to confirm they understand what they are meant to be taking and refer to the ward pharmacy team as appropriate. Ideally the nurse should cover what the medicine is for and any basic counselling such as how often to take them and common side-effects. This information can be found on the TTO reminder sheet in the patient's TTO bag.

2.4.10. Lastly the nurse should complete the 'ready to leave' screen on Maxims e-discharge and provide the patient with a print-out of the e-discharge. Completing this screen automatically sends a copy of the e-discharge to the GP and is a vital step in ensuring good communication between primary and secondary care. **Remember, this should only be done at the point of discharge.**

2.5. Expiry Date Management

2.5.1. Pharmacy will undertake monthly expiry date checks to those areas where pharmacy provides a top-up service i.e. most wards.

2.5.2. This expiry date check is limited to the treatment room top-up area and does not include decant stores such as drug trollies, clinic rooms, anaesthetic rooms and ward bay decant stores. It also does not cover IV fluids, feeds and the CD cupboard.

2.5.3. Any clinical area that stores medicines should have a monthly process in place for checking expiry dates of medicines which are not covered by the pharmacy top-up process.

2.5.4. Paperwork to support this process can be found in Appendix 3. These records should be kept in a folder in the clinical area as evidence that expiry date management is in place.

2.5.5. This task can be delegated to pharmacy with the appropriate funding but managing expiry dates remains a team responsibility as it is a dynamic situation where expiry dates change when products are reconstituted, liquids and creams are opened, and patients bring in their own supply.

2.5.6. Particular attention should be given to medicines stored in fridges and to liquid medicines, which often have a shortened expiry date once opened.

2.5.7. All staff need to remain vigilant to the risk of expired medicines and check not only the expiry date on the medicine container/box but also confirm whether this expiry date changes once the product has been opened, reconstituted etc.

2.5.8. On identifying expired medicines, staff should either dispose of the medicine in the clinical area (if they have the necessary waste processes in place) or segregate the stock immediately and return it to pharmacy as soon as possible for appropriate disposal.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	All elements of this policy will be monitored.
Lead	The matron, ward sister, ward pharmacist and ward technicians will monitor the policy as part of their daily working practice.
Tool	Datix's will be completed where non-adherence to the policy has resulted in an incident. Quantity of medicines returned from wards to dispose of. Clinical screening of the TTAs.
Frequency	Ongoing. An annual medicines management report is submitted to the Board which will include reference to medicines management performance.
Reporting arrangements	Aspects of the report will be reported to: The Senior Nurse and Midwifery Committee. The Medication Practice Committee.

Information Category	Detail of process and methodology for monitoring compliance
	The Medication Safety Group.
Acting on recommendations and Lead(s)	The Senior Nurse and Midwifery Committee (or equivalent). The Medication Practice Committee.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 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.

4. Equality and Diversity

4.1. 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.

4.2. Equality Impact Assessment

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

Appendix 1 Governance Information

Information Category	Detailed Information
Document Title	Good Medicines Management Clinical Guideline V6.0
This document replaces (exact title of previous version):	Good Medicines Management Clinical Guidelines V5.0
Date Issued/Approved:	29 August 2025
Date Valid From:	September 2025
Date Valid To:	September 2028
Directorate / Department responsible (author/owner):	Iain Davison, Chief Pharmacist
Contact details:	01872 252593
Brief summary of contents	How medicines are managed on the wards and the processes for ordering, transfer and discharge.
Suggested Keywords:	Medicines, drugs, medicines management.
Target Audience	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route (names of committees)/consultation:	Medication Practice Committee
Manager confirming approval processes	Iain Davidson, Chief Pharmacist
Name of Governance Lead confirming consultation and ratification:	Kevin Wright
Links to key external standards	Care Quality Commission. RPS safe storage.
Related Documents:	No
Training Need Identified?	Yes. Covered as part of medicines management awareness training and ward induction.

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 No	Summary of Changes	Changes Made by
12/12/2014	V1.7	Changes to reflect the move to electronic prescribing and the electronic ordering of medicines	Iain Davidson, Chief Pharmacist
06/12/2016	V3.0	Changes to reflect arrangements on patient transfer and discharge	Iain Davidson, Chief Pharmacist
28/8/2018	V4.0	Changes to include a section on expired medicines. Change of title to include other clinical areas	Iain Davidson, Chief Pharmacist
24/10/2019	V4.1	Included appendix with fridge monitoring template for use in contingency (previously part of the Medicines Policies Appendices section)	Iain Davidson, Chief Pharmacist
10/8/2020	V4.2	Amendments regards transfer process with ePMA implementation in CFT and hospices	Iain Davidson, Chief Pharmacist
28/6/2022	V5.0	General review. Minor changes to CFT discharge process. Addition of pharmacy assistants as able to assess PODs	Iain Davidson, Chief Pharmacist
6/8/2025	V6.0	General review. Removed reference to paper transfer process for hospices and CFT as now both on ePMA. Section 2.2. re not locking away specific time- critical medicines to reduce patient harm..	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 Initial 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:	Good Medicines Management Clinical Guideline V6.0
Directorate and service area:	All ward and clinical areas using medicines
Is this a new or existing Policy?	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)	It is aimed at hospital staff that are involved in the use of medicines. The guideline sets out the practical aspects of how medicines should be handled on the ward/ clinical area, on transfer and on discharge.
2. Policy Objectives	Safe, effective and legal use of medicines in the ward/ clinical environment.
3. Policy Intended Outcomes	The guideline aims to ensure there is a consistent approach to medicines management across all wards and clinical areas to minimise the risk of missed doses and to reduce waste.
4. How will you measure each outcome?	Ward audits, complaints and datixes.
5. Who is intended to benefit from the policy?	Patients and staff.

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 members.
6c. What was the outcome of the consultation?	Comments incorporated into the policy.
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:** Yes.

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	Applicable to all staff involved in medicines
Sex (male or female)	No	Applicable to all staff involved in medicines
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	Applicable to all staff involved in medicines
Race	No	Applicable to all staff involved in medicines
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Applicable to all staff involved in medicines
Religion or belief	No	Applicable to all staff involved in medicines
Marriage and civil partnership	No	Applicable to all staff involved in medicines

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	Applicable to all staff involved in medicines
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	Applicable to all staff involved in medicines

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

Appendix 3. Medicines Expiry Date Checks In Clinical Areas

Background

In clinical areas where pharmacy do not provide an expiry date checking service (for example, outpatient clinics, clinic rooms, anaesthetic rooms, drug trollies and feeds) it is the responsibility of the clinical service to ensure monthly expiry checks are taking place to remove any expired stock, eliminating the risk of patients receiving out of date medicines. It is the responsibility of the clinical lead for that area to ensure these checks are happening.

Process

1. Identify all areas within your department/ward/clinic that hold medicines stock that are not expiry date checked by pharmacy, this includes decant stores such as clinic and anaesthetic rooms, drug trollies and controlled drug cupboards.

2. Undertake a **MONTHLY** expiry check of those areas.

3. Record this monthly expiry check on the 'Expiry Date Check' form for that location.

4. Return any expired stock or stock going out of date that month immediately to pharmacy.

5. In the case of controlled drugs, attach a 'DO NOT USE' sticker to the product (available from pharmacy), segregate it at the bottom of the CD cupboard and contact pharmacy to return it.

6. Record any medicines going out of date in the following three months on the 'Short-dated items' form- allowing for easy identification of these medicines for removal at the next monthly expiry date check.

7. The clinical lead or nominated deputy should sign off the expiry checks have occurred each month and retain this record in the clinical area in an expiry date folder for two years.

Medicines Expiry Date Checks In Clinical Areas

YEAR: **Clinic/Ward/Department:**

	LOCATION						
EXAMPLE	Controlled Drug Cupboard	Feeds	Clinic Room 1	Anaesthetic Room 1	Drug Trolley	Ward bay drug storage cabinet	
	Checked by and Date	Checked by and Date	Checked by and Date	Checked by and Date	Checked by and Date	Checked by and Date	Clinical Lead Sign off
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							

Medicines Expiry Date Checks In Clinical Areas

YEAR: **Clinic/Ward/Department:**

	LOCATION						
	Checked by and Date	Checked by and Date	Checked by and Date	Checked by and Date	Checked by and Date	Checked by and Date	Clinical Lead Sign off
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							

Monthly Check of Short Dated Items

Clinic/Ward/Department:

Enter Month Of Checking	Item or Items Short Dated	Expiry Date	Checked By	Removed By

Appendix 4. Fridge Monitoring Templates (for contingency)

NOTE: Pharmacy monitors all drug fridges in the Trust via a central monitoring system. Please contact Pharmacy QA on x8382 for further information. The forms below are to be used if you have not yet had this monitoring system set up or for business continuity reasons.

Form 1

Fridge Temperature Record Sheet

Ward_____ **Month** _____ **Year** _____

The **temperature** must be between **2-8°c**. If the temperature is outside of these limits reset the thermometer and record the temperature again 2 hours later. If on the second reading the temperature is still out of range, then please inform the Ward Pharmacist and Estates. Out of hours, if possible move the medicines to a working fridge.

Date	1st reading						2nd Reading (2 hours later)						Comments
	Min Temp (°c)	Max Temp (°c)	Current Temp (°c)	Time	Read by	Reset by	Min Temp (°c)	Max Temp (°c)	Current Temp (°c)	Time	Read by	Reset by	
1													
2													
3													
4													
5													
6													
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11													
12													
13													
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15													
16													

Fridge Temperature Record Sheet

Ward_____ **Month** _____ **Year** _____

The **temperature** must be between **2-8°c**. If the temperature is outside of these limits reset the thermometer and record the temperature again 2 hours later. If on the second reading the temperature is still out of range, then please inform the Ward Pharmacist and Estates. Out of hours, if possible move the medicines to a working fridge.

Date	1st reading						2nd Reading (2 hours later)						Comments
	Min Temp (°c)	Max Temp (°c)	Current Temp (°c)	Time	Read by	Reset by	Min Temp (°c)	Max Temp (°c)	Current Temp (°c)	Time	Read by	Reset by	
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