Leicestershire Partnership NHS Trust

# Medicines Management Policy

This Policy describes the key processes for the handling of medicines within the Trust.

| | | |
|---|---|---|
| Key Words: | Medicines, Medication, Drug, Medicines Code, Prescribing, Administration | |
| Version: | 2 | |
| Adopted by: | Trust Policy Committee | |
| Date this version was adopted: | 17 December 2019 | |
| Name of author: (owner of policy) | Anthony Oxley | |
| Name of responsible committee: | Medicines Management Group | |
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| Expiry date: | August 2023 | |
| Target audience: | Clinical Staff | |
| Type of Policy | Clinical **X** | Non Clinical |
| Which Relevant CQC Fundamental Standards? | 12 Safe Care and Treatment | |

## CONTRIBUTION LIST

### Key individuals involved in developing the document

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# Contents

**Version Control and Summary of Changes**

| Version number | Date | Comments (description change and amendments) |
|---|---|---|
| 1.3 | 2nd March 2012 | Modified in line with Trust procedural document on policy production |
| 1.4 | March 2013 | Amendments incorporated to NHSLA Monitoring section (Appendix 2) |
| 1.5 | June 2014 | Reviewed and updated as part of standard review cycle |
| 1.6 | Jan 2015 | Reviewed and updated as part of standard review cycle |
| 1.7 | July 2017 | Reviewed and updated as part of standard review cycle |
| 1.8 | August 2018 | New section (6.8) added to allow treatment of members of the public who present for treatment at Trust premises |
| 1.9 | June 2019 | Reviewed and updated as part of standard review cycle. Section on items that can be stored outside medicine cupboard added |
| 2 | October 2020 | New section added (6.13) on how to manage prolonged breaks in treatment |

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**Equality Statement**

**Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.**

**It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.**

**This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.**

**In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.**

**This applies to all the activities for which LPT is responsible, including policy development and review.**

**Due Regard (All policies must be screened)**

**Standard statement for all policies.**
The Trust's commitment to equality means that this policy has been screened in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act 2010 to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity and foster good relations.

A due regard review found the activity outlined in the document to be equality neutral because they do not delineate activities down to an individual patient level.

## Definitions that apply to this Policy

| | |
|---|---|
| **Prescribing** | The act whereby a practitioner who is appropriately legally authorised produces an instruction for a specific patient to receive a specific medication. |
| **Administration** | The act of an appropriately legally authorised practitioner giving medication to a patient on the instruction of a prescriber |
| **Transfer** | Moving a patient from one discrete clinical area to another either within or out with the Trust |
| **Discharge** | The point in time at which a patient leaves in-patient or day-patient care |
| **Controlled Drug** | A product which has specific additional restrictions placed on its prescription, supply and/or storage by the Misuse of Drugs Act |
| **Private Patient** | A patient who at the time in question is not being treated for the relevant condition by the Trust |
| **Due Regard** | Having due regard for advancing equality involves:<br>• Removing or minimising disadvantages suffered by people due to their protected characteristics.<br>• Taking steps to meet the needs of people from protected groups |

| | |
|---|---|
| | where these are different from the needs of other people.<br>•Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low. |

## 1.0 Summary

This policy enshrines the Leicestershire medicines code into Trust policy and describes some additional Trust positions with respect to the management of medicines within the organisation.

## 2.0 Introduction

This policy is the overarching policy framework that supports the administration and prescribing sections of the Leicestershire Medicines Code which lays down medicines procedures for the Leicester, Leicestershire and Rutland Healthcare Community. As such, it ensures that following the procedures set down in the Medicines Code is a contractual responsibility for all staff involved in the handling of medicines.

Current version of the Medicines Code can be found here:

https://www.lmsg.nhs.uk/guidelines/secondary-care/medicines-code/

## 3.0 Purpose

The purpose of this policy is to ensure that following the procedures set down in the Medicines Code is a contractual responsibility for all staff involved in the handling of medicines.

## 4. Justification for Document

The justification for this policy is to ensure that following the procedures set down in the Medicines Code is a contractual responsibility for all staff involved in the handling of medicines.

## 5.0 Duties within the Organisation

5.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

5.2. Trust Board Sub-committees have the responsibility for ratifying policies and protocols. This policy will be overseen by the Quality Assurance Committee (QAC).

### 5.3 Staff

#### 5.3.1 Who may prescribe?

'Prescriber' is taken to mean any practitioner legally authorised to prescribe under the Medicines Act 1968 or subsequent amendments. Thus this policy applies equally and fully to both medical and non-medical practitioner prescribing.

There are two categories of prescribers:

**Independent Prescribers** - professionals who are responsible for the initial assessment of the patient and for devising the broad treatment plan, with the authority to prescribe the medicines required as part of that plan. This includes medical staff, dentists and authorised nurse and pharmacist prescribers who have successfully completed an independent prescribing course. Non-medical independent prescribers can prescribe any medicine for any medical condition within their clinical competence. Nurse and pharmacist independent prescribers are permitted to prescribe unlicensed medicines. They may also prescribe medicines independently for uses outside their licensed indications/UK marketing authorisation (so called “off licence” or “off label”). They must however accept professional, clinical and legal responsibility for that prescribing and should only prescribe “off label” where it is accepted clinical practice. The guidance for unlicensed medicines should be referred to.

**Supplementary Prescribers** - professionals who are authorised to prescribe certain medicines for patients whose condition has been diagnosed or assessed by an independent prescriber, which in this situation must be a medical practitioner, within an agreed clinical management plan (CMP). Professionals who can undertake supplementary prescribing are nurses, pharmacists and certain allied health professionals (chiropodists/podiatrists, physiotherapists and radiographers). Supplementary and independent prescribers must be registered as such with the relevant regulatory body and any activity carried out by them must have Trust approval and authorisation.

Where a nurse or a pharmacist is the supplementary prescriber, a CMP may include any General Sales List, Pharmacy or Prescription Only Medicine prescribable at NHS expense. This includes the prescribing of controlled drugs (except those listed in schedule 1 of the Misuse of Drugs regulations), unlicensed and off label medicines. When the latter occurs, such use must have the joint agreement of both prescribers and the status of the medicines should be recorded in the CMP.

**Allied health professional supplementary prescribers** are not allowed to prescribe controlled drugs.

**Dietician Initiated Nutrition and / or Dietary Therapy**

Registered Dieticians are authorised to initiate the use of nutrition and / or dietetic products (Borderline substances) by entering them on the inpatient prescription. Dietetic products may include sip nutritional supplements, enteral tube feeds, single/combined source (fat, carbohydrate, protein) supplements, thickeners, gluten, low protein and metabolic products, vitamins and minerals.

## 6.0 Processes

### 6.1 Transfers

A copy of the prescription should accompany the patient and his/her case notes during transfer to a ward that cannot access that prescription electronically.

On arrival at a new ward within the same hospital or at a new hospital within Leicestershire, the original prescription chart should be used and the ward or hospital identification be amended, provided the new ward normally uses the same chart as the original. Otherwise all prescriptions should be re-written on the chart normally in use on the ward or if revision of therapy is needed because of transfer to another medical team. This also applies to respite care.

For transfers to hospitals outside of Leicestershire, a letter giving details of current medicines and their original starting date should accompany the patient. If the patient is likely to need treatment en route, the prescription chart and an adequate supply of medicines should accompany him/her. The prescription chart's validity ceases on arrival at the new hospital and should then be filed in the notes of the original hospital.

Where the patient's own medicines, prescribed by their GP, have been retained on the ward they must accompany the patient to the new ward or hospital.

Any non-standard/non-stock medicines should also be sent with careful detailed instructions as to their use. The transferring ward must ensure, prior to the transfer of the patient, that the receiving ward can continue treatment without interruption.

### 6.2 Discharge Medication (TTOs)

A full prescription should be produced for all medicines to be dispensed at discharge. Any changes made to the medicines regime since admission should be highlighted on the discharge letter. Medicines which the patient has brought in and whose use is to continue at home, should be returned to the patient on discharge, providing this medication has at some stage been checked by a pharmacist or accredited pharmacy checking technician.

Prescribers must include all medication required, including patient's own, on the discharge letter/TTO.

Instructions should be given to the patient to obtain further supplies from their GP.

For short courses, the precise number of days therapy required should be stated.

All members of the healthcare team have a duty to ensure that the patient is made aware of, and understands, any changes made to their medication regime since admission i.e. new medicines, changes in dose, stopped medicines, switching of one medicine for another.

The prescription should be endorsed 'patient own drug' (POD) when the patient has sufficient supplies at home.
A pharmacist should check the discharge prescription for accuracy and appropriateness compared with the in-patient prescription.

For medicines issued to patients being discharged from hospital, the registered

nurse must check the dispensed medicine against the discharge letter. It is good practice to involve a second checker if available, who could be a registered nurse or the ward pharmacist or technician.

The registered nurse must hand over the medicines to the identified patient or their responsible carer and ensure that the following explanation/detail is given:

- The administration details on each bottle/package of medicines must be read out to the patient/carer, including instructions on storage, e.g. store in a refrigerator
- The nurse must explain to the patient/carer how and when the medicines should be taken and detail any potential (common) side effects, e.g. drowsiness.

### 6.3 Controlled Drugs for outpatient and discharge prescriptions

By law the prescription must always state:-

- The name and address of the patient
- The patient's NHS number
- In the case of a preparation, the form and, where appropriate, the strength of the preparation
- The dose
- The total quantity of the preparation, or the number of dose units, **in both words and figures,** e.g. morphine sulphate controlled release (MST) tablets, 30mg bd – fourteen (14) x 30 mg tablets.

The above can be handwritten or be computer generated. The prescriber's signature must be handwritten and not computer generated. If pre-printed sticky labels are used, including the use of addressographs, prescribers should also sign on the sticky label to ensure that sticky labels are not tampered with or another sticky label is not placed on top of the one that the prescriber has signed for.

A maximum of 30 days supply can be prescribed, and prescriptions will only be valid for 28 days from the date of signature or any other date on the prescription as the date before which the drug should not be supplied – whichever is later. In circumstances where the patient is known to be a drug misuser, no more than 24 hours supply of controlled drugs should normally be given except by the specialist team providing substance misuse services.

Where a Community Nurse is to administer medication, a copy of the prescription, containing the name, address and medicine details, signed and dated by the medical practitioner must be provided.

### 6.4 Out-patient prescribing

When it is necessary for a new treatment to be initiated by the hospital prescriber, or where a dose adjustment of existing therapy necessitates a new dosage form, an outpatient prescription should normally be produced and a treatment supply of twenty- eight days/nearest whole pack or as appropriate dependant on individual

patient needs should be given. The patient will be advised to obtain further prescriptions from their GP, except when the medicine is in the amber or red or black categories of the Leicestershire Medicines Strategy Group traffic light classification system. See www.lmsg.nhs.uk for further details. Local health community contracts do allow for GPs to be asked to initiate non-urgent prescriptions for drugs not classified as shared care or hospital only but this should only be used when the patient is happy with this option and it will not cause any clinical detriment.

'Amber' medicines are initiated in hospital and then transferred to the GP under a Shared Care Agreement. Care should only be transferred when the Health Community approved shared care agreement requirements for that medicine have been met and the GP is confident to continue prescribing and take over the care of the patient. Written communication will be sent to the GP, to confirm the rationale for initiation.
'Black' medicines are medicines which are not recommended for use in the Leicestershire Health Community and should not be prescribed or recommended by either secondary or primary care clinicians.

A record of the prescribed medication, including the dose and duration, should be entered in the patient's notes. The prescriber should ensure rapid communication to the GP. The GP must be given sufficient information on therapies that he/she would not normally be familiar with. The prescriber should ensure that the appropriate patient information leaflet is given to the patient.

Unlicensed medicines should be prescribed and supplied in accordance with locally agreed guidelines. Preparations in the children's BNF are considered to be quasi-licensed in the Leicestershire and Rutland healthcare community. GPs may refuse to prescribe unlicensed medicines.

An outpatient prescription given to a patient for supply from the hospital pharmacy is valid for 3 months from the date of issue, with the exception of controlled drug prescriptions, which are valid for 28 days from the date of issue.

### 6.5 Day Hospitals

Where a Day Hospital is responsible for supplying medication to a patient a formalised procedure should exist for the medicines required to be issued by the Pharmacy Department.

### 6.6 Medical Students

By law, medical students are not permitted to prescribe

### 6.7 Self-Prescribing Policy

#### 6.7.1 Doctors

General Medical Council and BMA guidance on this issue is that doctors and their families should be registered with a general practitioner outside the family who takes responsibility for their healthcare. This gives them ready

access to objective advice and avoids conflicts of interests that can arise when doctors treat themselves or those close to them. It is acceptable for a doctor to treat minor ailments or to take emergency action when necessary. Doctors should avoid treating themselves or close family members whenever possible. This is a matter of common sense and good medical practice.

Hospital pharmacies will dispense prescriptions for small quantities of medicines for the treatment of acute conditions for clinicians employed by their organisation. However,

- Drug choice is restricted to that included within the Leicestershire Prescribing Guide

- NHS prescription charges and exemptions from prescription charges will apply.

Prescriptions for hypnotics, sedatives, anxiolytics, controlled drugs, oral contraceptives and anti-psychotics will not be dispensed.

### 6.7.2 Non-Medical Prescribers

The NMC and RPSGB advise that Non-Medical Prescribers should not prescribe any medicine for themselves. Non-medical Prescribers are accountable for their practice at all times, and if a situation arises where they find themselves in a position to prescribe for their family or friends, then they must accept accountability for that decision. It is strongly recommended that Non-Medical Prescribers do not prescribe for anyone with whom they have a close personal or emotional relationship other than in exceptional circumstances.

## 6.8 Prescribing for members of the public who present at Trust sites

If a member of the public presents at an LPT setting requiring emergency medical attention that cannot be provided in a timely manner through other approved routes, emergency medication can be prescribed and administered within the clinical competence of the available prescriber(s). If no prescriber is available, only medications approved under common law to save life (e.g. Naloxone) can be given.

All prescribing and administration should be carried out in line with the current Leicestershire Medicines Code

A 999 Call must be initiated for emergency response.

Medication should be prescribed and administration recorded on a paper drug chart and there should be handover of relevant information to those who will provide ongoing patient care.

An E-IRF should be completed as soon as the incident has been managed.

### 6.9 Staff's own medication

There are situations where staff will need to bring in or keep their own medication in a work environment. If the staff member works in an area to which patients have access, the medication must be stored securely in a location that does not permit patient access. The Trust takes no responsibility for the use or quality of such medication and in all except life threatening conditions it should be administered by the staff member themselves. If necessary to save a life e.g. an Adrenaline auto-injector for anaphylaxis, another staff member could administer the medication under common law.

### 6.10 Administration Points

#### 6.10.1 Oral Syringes

In order to minimise the risk of medication being inadvertently administered by the wrong route, National Patient Safety Agency guidance was that:-

- Only oral/enteral syringes that are not compatible with intravenous and other parental devices are used to measure and administer oral liquid medicines/ enteral feeds to patients
- The colour purple should be adopted for use in oral/enteral devices to aid differentiation between oral/enteral and other devices in practice.
- Naso-gastric and enteral feeding tubes, administration and extension sets should be labelled to indicate the route of administration at both the proximal and distal ends of the tube, as appropriate.
- Nasogastric and enteral feeding tubes, administration and extension sets must not contain any in-line female luer ports, or male luer terminal connectors (tips).
- Three way taps must not be used in oral/enteral feeding systems
- Adaptors that convert oral/enteral syringes into devices that can connect with intravenous/parental connectors must not be used.

#### 6.10.2 Administration of Medicines by Medical Staff

It is unacceptable to prepare medicines in advance of their immediate use or to prepare medicines for administration by others.

It is unacceptable to administer medicines prepared by another practitioner if this practitioner is not present.

Exceptions to this include ready-made preparations from pharmacy, or continuous or intermittent infusion by some kind of infusion device already in place. In these circumstances the following criteria must exist:-

A valid prescription:-

- The container must be clearly labelled, signed and dated
- Accurate administration records are kept including the name of the person who initiated the infusion
- Once these checks have taken place the registered nurse who has accepted

responsibility for the patient's care is accountable for the administration of the medicine.

### 6.10.3 Self-administration of Medicines

Self-administration of medicines is supported whenever it is appropriate and providing the necessary security, storage and assessment and monitoring arrangements are available.

Before commencing self-administration two parameters should be filled:

- The service user's drug treatment has been reviewed and is as simple and rational as possible
- The service user understands they are self-administering their medicines and has signed the consent form to do so.

**AN EXAMPLE PROGRAMME FOR SELF-ADMINISTRATION IN A MENTAL HEALTH REHABILITATION SETTING CONSISTS OF 5 STAGES:**

**Stage 1:** Medication supplied as 7 days' supply and kept by nursing staff between doses

**Stage 2:** Medication supplied as a single day's supply

**Stage 3:** Medication supplied as 2 days' supply

**Stage 4:** Medication supplied as 3 – 4 days' supply

**Stage 5:** Medication supplied as 7 days' supply and collected by the patient from pharmacy, (where appropriate):
The service user starts at Stage 1 and progresses to Stage 5. The service user should be continually assessed with a view to moving on to the next stage. Each stage should be a minimum of 7 days and should not continue for more than 4 weeks without review. When Stage 5 is successfully completed the service user should be capable of being responsible for their own medication on return to the community.

### 6.11 Side effect monitoring

All qualified clinicians caring for patients are responsible for monitoring patients for side effects. Patients should be asked about any adverse reactions to medications on a regular basis. This may be at 6-monthly intervals or at each appointment whichever is the longer. If side-effects are observed or reported the patient should be asked if they are troublesome and any side-effects which are considered to be unacceptable to the patient should be brought to the attention of a prescriber responsible for the care of the patient so that therapy can be reviewed

Information will be available on request in a format suitable for the individual patient; for example, large print, another language, Braille etc, to ensure no patient is disadvantaged in the context of any aspect of this policy and its implementation. This

will include appropriate referral to the Trust Interpretation and Translation Service (refer to Intranet).

### 6.12 Storage of medicines outside medicines cupboards

In line with the medicines code all medications should be stored in a medication cupboard at ward level. However, to facilitate ease of access and due to their low clinical risk the following items may be retained by the patient:

Reliever Inhalers (e.g. Salbutamol)

Lubricant Eye Drops

Anusol Cream/Ointment

Glyceryl Trinitrate Spray

### 6.13 Prolonged non-compliance or other breaks from medication

Where patients have not taken some or all of their medication for a prolonged period e.g. in excess of two weeks and they are taking a dose higher than the stated initiation dose in the BNF, care should be taken when medication is re-introduced including taking advice from an experienced prescriber or from a pharmacist. This is particularly important when the patient is receiving high-dose therapy. Separate arrangements exist for Clozapine where the drug regime must be re-escalated if the patient has not taken any for more than 48 hours.

### 6.14 Expiry dates of medicines that patients bring into hospital

If no expiry date is shown on a product that a patient brings with them into hospital, either from home or from another healthcare provider, it must be used within 4 weeks of the date of dispensing shown on the dispensing label. If it has no dispensing label on it then it should not be used and a new supply ordered from pharmacy.

## 7.0 Training

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as mandatory training.

The Trust will provide training in the operation of this policy to all qualified nurses, nurse co-ordinators and medical staff and this training will be recorded within the Trust Mandatory Training Register. Attendance at this training will be mandatory and will be repeated every 2 years.

The course directory available on e- source will identify: who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training.

A record of the event will be recorded on the Trust's uLearn system.

The governance group responsible for monitoring the training is the Medicines Management Group.

## 8.0 Stakeholders and Consultation

The involvement of relevant groups, committees and stakeholders is key to the review and development of authorized documents. This policy has been developed by the Trust Medication Risk Reduction Group which has multi-professional and multiservice representation. Members of the group have consulted with relevant stakeholders within their own services.

## 9.0 Monitoring Compliance and Effectiveness

Monitoring of this policy is carried out as part of the Medicines Code audit carried out as part of the Trust's quality schedule monitoring. This audit is carried out annually using an approved methodology – the lead auditor will be the Trust Head of Pharmacy. Any action plans required will be developed by the Trust's medication risk reduction group and agreed by the Trust's commissioners as part of the quality schedule monitoring process.

## 10.0 Links to Standards/Performance Indicators

The safe management of medicines features in the safety domain of the CQC's standards framework.

**10.1** Standards/Key Performance Indicators –

| **TARGET/STANDARDS** | **KEY PERFORMANC**E **INDICATO**R |
|---|---|
| Only appropriately registered professionals will prescribe medicines | 100% of medicines are prescribed by a practitioner qualified to do so |
| A full prescription should be produced for all medicines to be dispensed at discharge | 100% of patients will receive the medication they require at the point of discharge |
| Self medication is supported whenever it is appropriate | A risk assessment will be carried out in 100% of cases where a patient requests to self-medicate and if the risk assessment shows low/no risk the patient will be supported to self medicate |
| Clinicians are responsible for monitoring patients for side effects | 100% of patients' clinical records who are receiving medication will document an assessment of side effect burden at least annually. |

**References and Associated Documentation**

This policy was drafted with reference to the following:

LPT Drug Error Policy 2019

LPT Non-Medical Prescribing Policy 2019

DoH Safer Management of Controlled Drugs

Medicines, Ethics and Practice – A guide for pharmacists

NMC Code of Professional Conduct

The safe & secure handling of medicines RPSGB

Misuse of Drugs Regulations 2006

NPSA Patient Safety Alert 19: Promoting safer administration of liquid medicines

**Appendix 1**

# Policy Training Requirements

| | |
|---|---|
| **Training topic:** | |
| **Type of training:** | ☒ Mandatory (must be on mandatory training register)<br>☐ Role specific<br>☐ Personal development |
| **Division(s) to which the training is applicable:** | ☒ Adult Learning Disability Services<br>☒ Adult Mental Health Services<br>☒ Community Health Services<br>☒ Enabling Services<br>☒ Families Young People Children<br>☐ Hosted Services |
| **Staff groups who require the training:** | *All registered nurses, pharmacists and medical staff* |
| **Update requirement:** | Every three years |
| **Who is responsible for delivery of this training?** | Pharmacy Services |
| **Have resources been identified?** | Yes |
| **Has a training plan been agreed?** | Yes |
| **Where will completion of this training be recorded?** | ☒ Trust learning management system<br>☐ Other (please specify) |
| **How is this training going to be monitored?** | Audit of uLearn system |

**Appendix 2**

## Policy Monitoring Section

**Criteria Number & Name: Medicines Management Policy:**
**Medicines Management Policy / Medicines Code**

Duties outlined in this Policy will be evidenced through monitoring of the other minimum requirements

Where monitoring identifies any shortfall in compliance the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance

| Reference | Minimum Requirements | Self assessment evidence | Process for Monitoring | Responsible Individual / Group | Frequency of monitoring |
|---|---|---|---|---|---|
| 5 | All prescriptions are produced by appropriately qualified individuals | | Medicines Code Audit | MRRG | Annually |
| 6.3 | Controlled drug prescriptions comply with legal requirements | | Controlled Drug Audit | MRRG | Annually |
| 6.4 | GPs will not be asked to prescribe “red” or “black” medicines by LPT clinicians | | Traffic light compliance audit (Quality Schedule) | Medication Management Group | Annually |

Leicestershire Partnership NHS Trust

# The NHS Constitution

## NHS Core Principles – Checklist

## Please tick below those principles that apply to this policy

**The NHS will provide a universal service for all based on clinical need, not ability to pay.**
**The NHS will provide a comprehensive range of services**

| | |
|---|---|
| **Shape its services around the needs and preferences of individual patients, their families and their carers** | ☐ |
| **Respond to different needs of different sectors of the population** | ☐ |
| **Work continuously to improve quality services and to minimise errors** | X |
| **Support and value its staff** | ☐ |
| **Work together with others to ensure a seamless service for patients** | X |
| **Help keep people healthy and work to reduce health inequalities** | ☐ |
| **Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance** | X |

**Appendix 4**

## Due Regard Screening Template

| **Section 1** | |
|---|---|
| **Name of activity/proposal** | Medicines Management Policy |
| **Date Screening commenced** | 23rd October 2019 |
| **Directorate / Service carrying out the assessment** | Pharmacy |
| **Name and role of person undertaking this Due Regard (Equality Analysis)** | Anthony Oxley, Head of Pharmacy |
| **Give an overview of the aims, objectives and purpose of the proposal:** | |
| **AIMS: Ensure safe use of medicines within the Trust** | |
| **OBJECTIVES:** Ensure the principles of safe prescribing, administration, dispensing and storage of medicines are enshrined within Trust policy. | |

| **Section 2** | |
|---|---|
| **Protected Characteristic** | **If the proposal/s have a positive or negative impact please give brief details** |
| Age | No impact |
| Disability | No impact |
| Gender reassignment | No impact |
| Marriage & Civil Partnership | No impact |
| Pregnancy & Maternity | No impact |
| Race | No impact |
| Religion and Belief | No impact |
| Sex | No impact |
| Sexual Orientation | No impact |
| Other equality groups? | No impact |

| Section 3 | | | |
|---|---|---|---|
| **Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.** | | | |
| Yes | | No | |
| High risk: Complete a full EIA starting click here to proceed to Part B | | Low risk: Go to Section 4. | √ |

| Section 4 | | | |
|---|---|---|---|
| **If this proposal is low risk please give evidence or justification for how you reached this decision:** | | | |
| There are no significant changes from existing policy which was deemed to be low risk when previously screened | | | |
| **Signed by reviewer/assessor** | Anthony Oxley | **Date** | 23rd October 2019 |
| *Sign off that this proposal is low risk and does not require a full Equality Analysis* | | | |
| **Head of Service Signed** | Anthony Oxley | **Date** | 23rd October 2019 |

Appendix 5

## DATA PRIVACY IMPACT ASSESSMENT SCREENING

| | | | |
|---|---|---|---|
| **Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.**<br>**The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.** | | | |
| **Name of Document:** | **Medicines Management Policy** | | |
| **Completed by:** | **Anthony Oxley** | | |
| **Job title** | **Head of Pharmacy** | | **Date 30th October 2019** |
| **Screening Questions** | | **Yes / No** | **Explanatory Note** |
| **1.** Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document. | | No | |
| **2.** Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document. | | No | |
| **3.** Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document? | | No | |
| **4.** Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used? | | **No** | |
| **5.** Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics. | | No | |
| **6.** Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them? | | No | |
| **7.** As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private. | | No | |
| **8.** Will the process require you to contact individuals in ways which they may find intrusive? | | **No** | |
| **If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk**<br>**In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.** | | | |

| | |
|---|---|
| **Data Privacy approval name:** | |
| **Date of approval** | |

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

**Data Privacy Impact Screening Guidance Notes**

The following guidance notes should provide an explanation of the context for the screening questions and therefore assist you in determining your responses.

**Question 1:** Some policies will support underpinning processes and procedures. This question asks the policy author to consider whether through the implementation of the policy/procedure, will introduce the need to collect information that would not have previously been collected.

**Question 2:** This question asks the policy author if as part of the implementation of the policy/procedure**,** the process involves service users/staff providing information about them, over and above what we would normally collect

**Question 3:** This questions asks the policy author if the process or procedure underpinning the policy includes the need to share information with other organisations or groups of staff, who would not previously have received or had access to this information.

**Question 4:** This question asks the author to consider whether the underpinning processes and procedures involve using information that is collected and used, in ways that changes the purpose for the collection e.g. not for direct care purposes, but for research or planning

**Question 5:** This question asks the author to consider whether the underpinning processes or procedures involve the use of technology to either collect or use the information. This does not need to be a new technology, but whether a particular technology is being used to process the information e.g. use of email for communicating with service users as a primary means of contact

**Question 6:** This question asks the author to consider whether any underpinning processes or procedures outlined in the document support a decision making process that may lead to certain actions being taken in relation to the service user/staff member, which may have a significant privacy impact on them

**Question 7:** This question asks the author to consider whether any of the underpinning processes set out how information about service users/staff members may intrude on their privacy rights e.g. does the process involve the using specific types of special category data (previously known as sensitive personal data)

**Question 8:** This question asks the author to consider whether any part of the underpinning process(es) involves the need to contact service users/staff in ways that they may find intrusive e.g. using an application based communication such as WhatsApp

If you have any further questions about how to answer any specific questions on the screening tool, please contact the Data Privacy Team via LPT-DataPrivacy@leicspart.secure.nhs.uk