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Patient's Own Drugs Policy

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Consultation Groups	ELFT pharmacy team ELFT medicines committee
Approved by (Sponsor Group)	Medicines Committee
Ratified by:	Medicines Committee
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Services	Applicable
Trustwide	
Mental Health and LD	√
Community Health Services	
Primarycare	

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Version Control Summary

Version	Date	Author	Status	Comment
1.0	June 2011	Manpreet Saini, former Lead Directorate Pharmacistfor Community Health Newham (ELFT)	Final	All references specifically to East HamCare Centre and Newham University Hospital removed
2.0	July 2015	Manpreet Saini, former Lead Directorate Pharmacistfor Community Health Newham (ELFT)	Final	3.0: Addition of definitionof Patients' own drugs. 5.2: Removal of use ofPODs bags. 6.2: Removal of Nurse orDoctor as professionals making PODs suitability assessments. 6.6: Addition of line that patient should not be left without medication whilst relabeling of PODs occurs. 9.3: TTA marked with'Ward' if patient has medication to be discharged with.
3.0	August 2021	Susana Fontelo Rojano, Lead Pharmacist City and Hackney Centre for Mental Health and Forensic	Draft	Policy template updated as per 'Trust policy for development and management of procedural documents' 1.0: addition of: PODs are the property of the patient and must not be used or destroyed without consent, PODs cannot be used for any patient other than for the named individual. PODs can also be brought to the ward during the admission. Addition of line: patient medications are suitable and safe for use and safe handling while on an inpatient ward. reducing potential risk of harm (expired drugs, misuse, overdose) 2.0: addition of "use" 3.2: addition: accredited pharmacy Assistant Technical Officer (ATO) 4.1& 4.2: addition of "family" 4.3: addition: ATO 4.4 addition: All PODs should be stored securely until the ward based pharmacy

				team has assessed suitability and/or are returned to the patient. 5.2: addition: ATO 5.3: addition: ATO and of “electronic” 5.4: reworded to - endorse the electronic prescription chart by highlighting the patient “has own medication supply” in the order notes section of the drug entry within the electronic medication chart 5.6: identified changed to assessed 6.1 addition of ‘treatment room’ 6.2 Out of hours, the on-call pharmacist can remotely provide guidance to a nurse to assess the PODs. 7.1: addition of “and there is a need to use POD’s” 7.1: addition of “electronic discharge prescription chart”

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1. Introduction

Patients' own drugs (PODs) are defined as medicines that are the legal property of the patient; they have been prescribed for, or purchased by, the patient.

- PODs usually come from a patient's own supply from home or as part of discharge medication from outside the hospital Trust. PODs can also be brought to the ward during the admission.
- PODs are the property of the patient and must not be used or destroyed without consent
- PODs cannot be used for any patient other than for the named individual
- It may be appropriate to use PODS if the medication has been prescribed by ELFT but is not approved within the trust e.g. non formulary and consequently is not normally available within the Trust PODs can be used when alternative supplies are not available (e.g. night time, weekend or bank holiday admissions)
- PODs can be used for self-administration as per Trust's policy 'Self-administration of medicines (SAM) by inpatients' or for administration by nursing staff inplace of a supply being obtained from the Pharmacy Service

A policy for handling patients' own drugs (PODs) is needed to ensure that:

- patient medication histories are accurate
- the continuity of patient medication is not disrupted
- patient medications are suitable and safe for use
- safe handling while on an inpatient ward
- wastage is reduced by minimizing
  - unnecessary destruction of PODs
  - re-dispensing of medicines
- discharge is improved by
  - reducing waiting times for discharge medications
  - helping patients understand which medicines they should/shouldn't use
  - reducing potential risk of harm (expired drugs, misuse, overdose)

3. Purpose

This policy covers the assessment, the handling and use of patients' own medicines

brought in by patients during their stay as an inpatient in hospital.

4. Duties and responsibilities

4.1 It is the responsibility of all staff involved in any aspect of this policy to inform their manager of any variation in practice or inability to follow the processes defined.

4.2 It is the responsibility of the nurses, pharmacist, Medicines Management Technicians (MMT) and accredited pharmacy Assistant Technical Officer (ATO) to follow this policy as part of their ward based service.

5. Management of PODs: on admission

5.1 To enable an accurate patient medication history to be taken, patients/family/carer(s) should be encouraged to bring all their current medicines into hospital. Appendix I.

5.2 Following emergency admissions, all patients must be asked if they brought in medicines from home. If the patient didn't bring any medication, the family/carer(s) should be asked to bring in the patient's own supply and relevant information (e.g. repeat prescription, recent discharge letter) as soon as possible.

5.3 Receipt of PODs should be documented in the patients RIO notes by the person receiving them. Documentation should include drug name and quantity and that the ward based pharmacy team (pharmacist, MMT and/or ATO) has been informed or not.

5.4 All PODs should be stored securely in the POD cupboard, controlled cupboard and/or medication fridge until the ward based pharmacy team has assessed suitability.

6. Management of PODs: during a hospital inpatient stay

6.1 PODs will be used routinely. Where a suitable POD is not available a supply will be made from ward stock or individually dispensed by the pharmacy. If a limited supply of PODs is available, it may be more appropriate to use these for discharge medication and for the inpatient supply to be provided by the pharmacy or from stock supplies on the ward.

6.2 All PODs should be assessed for suitability for use against the criteria in Appendix II. This can be carried out initially by a Pharmacist, MMT and/or ATO. Out of hours, the on-call pharmacist can remotely provide guidance to a nurse to assess the PODs if required.

6.3 At the earliest opportunity a Pharmacist, MMT or ATO must assess or reassess the quality of the medicine being used on the ward. Any discrepancy between the directions on the PODs, the instructions on the electronic/paper prescription chart or information from the patient must be brought to the attention of the pharmacist as part of the usual medicines reconciliation process.

6.4 The pharmacy staff will endorse the electronic or paper prescription chart by highlighting "has own medication supply" within the order notes section of the drug entry of the electronic

prescription chart or the additional instructions section on the paper chart.

6.5 Additionally, all staff that check PODs will initial and date the PODs stickers if the quality of the PODs are satisfactory.

6.6 PODs which have been satisfactorily assessed but need repackaging, labelling or re-labelling should be taken/returned to the pharmacy in a bag labelled with the patient's name, ward, date and the words *"For repackaging/labelling/re-labelling"* as appropriate. Where necessary, dosing instructions must accompany the medicines on the usual ward requisition form. These PODs will be returned to the ward as soon as possible, though the patient must NOT be left without any medicines whilst this occurs.

6.7 Where a POD is to be self-administered by the patient the Trust's policy for 'Self-administration of medicines (SAM) by inpatients' must be followed.

6.8 If the patient transfers to another ward any PODs, either in storage or in use, must accompany the patient

6.9 Ward storage of PODs

6.9.1 PODs routinely will be stored in a locked cupboard or fridge in the treatment room however PODs could also be stored in individual patient lockers to be self-administered as per 'Self-administration of medicines (SAM) by inpatients' policy.

6.9.2 If PODs are not being used during the inpatient stay they must be stored securely until discharge in the bedside locker where installed or in a locked cupboard in the treatment room.

6.9.2 PODs that are Controlled Drugs (CDs) must be stored in the CD cupboard and entered into the CD Register as per trust policy on handling and storage of CDs.

7. Management of PODs: on discharge

7.1 If a discharge prescription is generated the pharmacist or MMT should assess suitability of PODs to be used as discharge medication and annotate this on the discharge prescription. If unsuitable for discharge use, the PODs should be destroyed and new supply made to avoid confusion. If the electronic or paper prescription chart is dealt with on the ward, the Pharmacist or ward based Technician will check the PODs in the bedside locker or treatment room against the electronic discharge prescription chart. The electronic discharge prescription chart will be endorsed according to the trust's endorsement policy. If everything is present a sticker will be stuck to the bag to say 'ready for discharge'. If any new drugs need to be added then a sticker will be placed to say 'waiting for xxxxx' to be added to bag. The pharmacy department will send the bag back to the appropriate ward when the new items are ready.

7.2 PODs may be used for the discharge medication provided the patient has at least a 2-week supply either at home, (determined by interview with a Pharmacist, Pharmacy Technician, Nurse) or in the hospital. Otherwise, a supply should be made from the hospital pharmacy. If using home supplies, the electronic prescription chart and the discharge summary must be clearly endorsed with "Patient's own" on the electronic prescription chart.

7.3 If PODs are to be used on discharge, the pharmacy will endorse the electronic discharge prescription chart 'PODs'.

7.4 On discharge, any medications belonging to the patient that are no longer required should be sent to Pharmacy for destruction. The patient must be informed of this in case of objection.

7.5 If patient lockers are in use, they should be cleared of all medications at the point of discharge.

8. Destruction of PODs

8.1 It may be appropriate to destroy a POD in the following circumstances:

- The medicine has been stopped
- An alternative strength/preparation has been prescribed
- The medicine is assessed as not being suitable for use (e.g. it is out of date) see Appendix II

8.2 Where it is appropriate to destroy a POD the reason should be explained to the patient/family/carer(s). The details of the POD(s) to be destroyed should be written in the appropriate space on the inpatient electronic prescription chart or the patient's medical records. A Pharmacist, Pharmacy Technician, Nurse or Doctor can carry out this process.

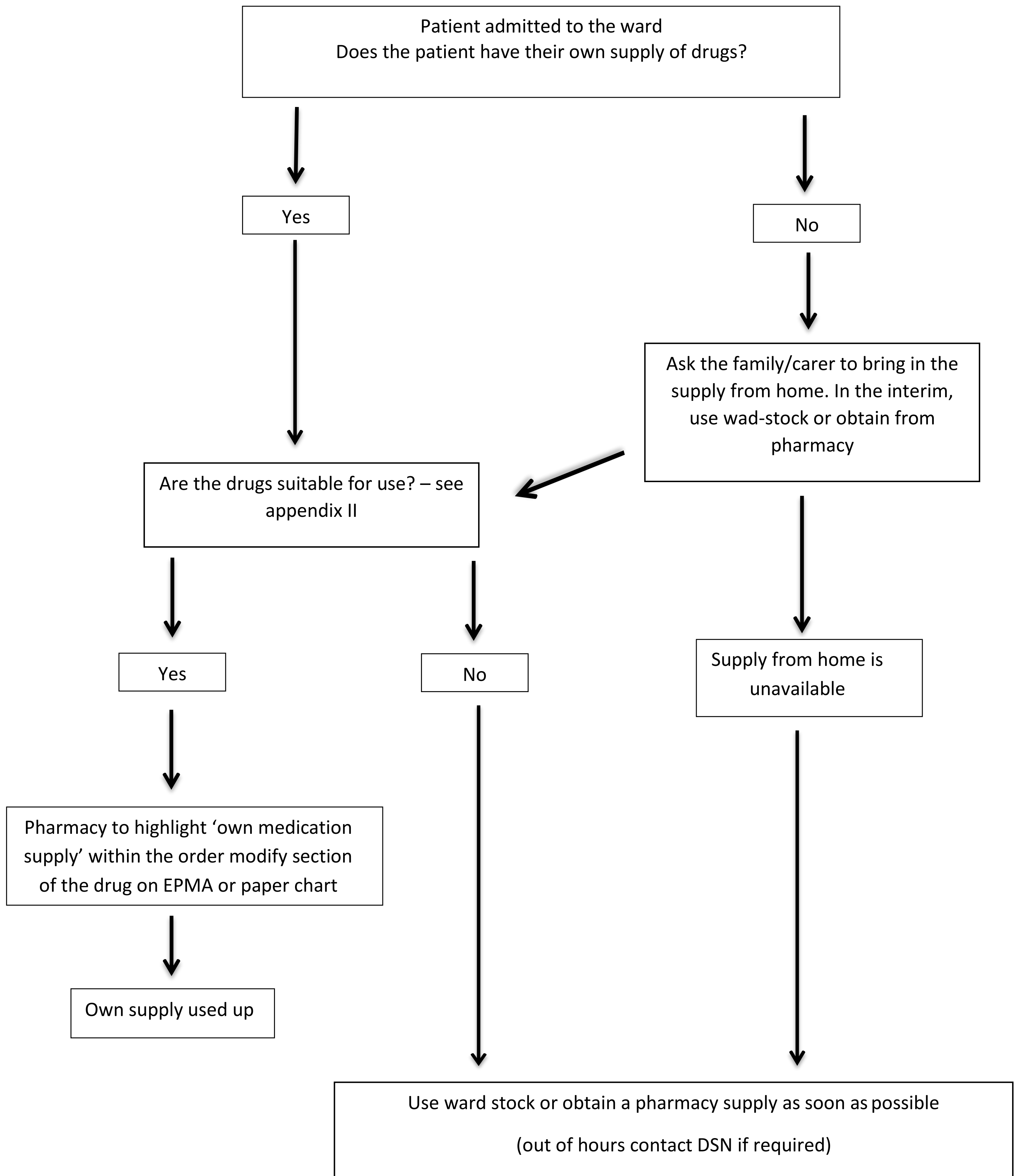
8.3 PODs for destruction must be handled in line with the trust's policy for destruction of medicines.

8.4 If the patient refuses consent for appropriate destruction of PODs, their wishes should be respected. These PODs should be returned to the patient and a note made in the patient's medical records. A Pharmacist, Pharmacy Technician, Nurse, Midwife or Doctor can carry out this process.

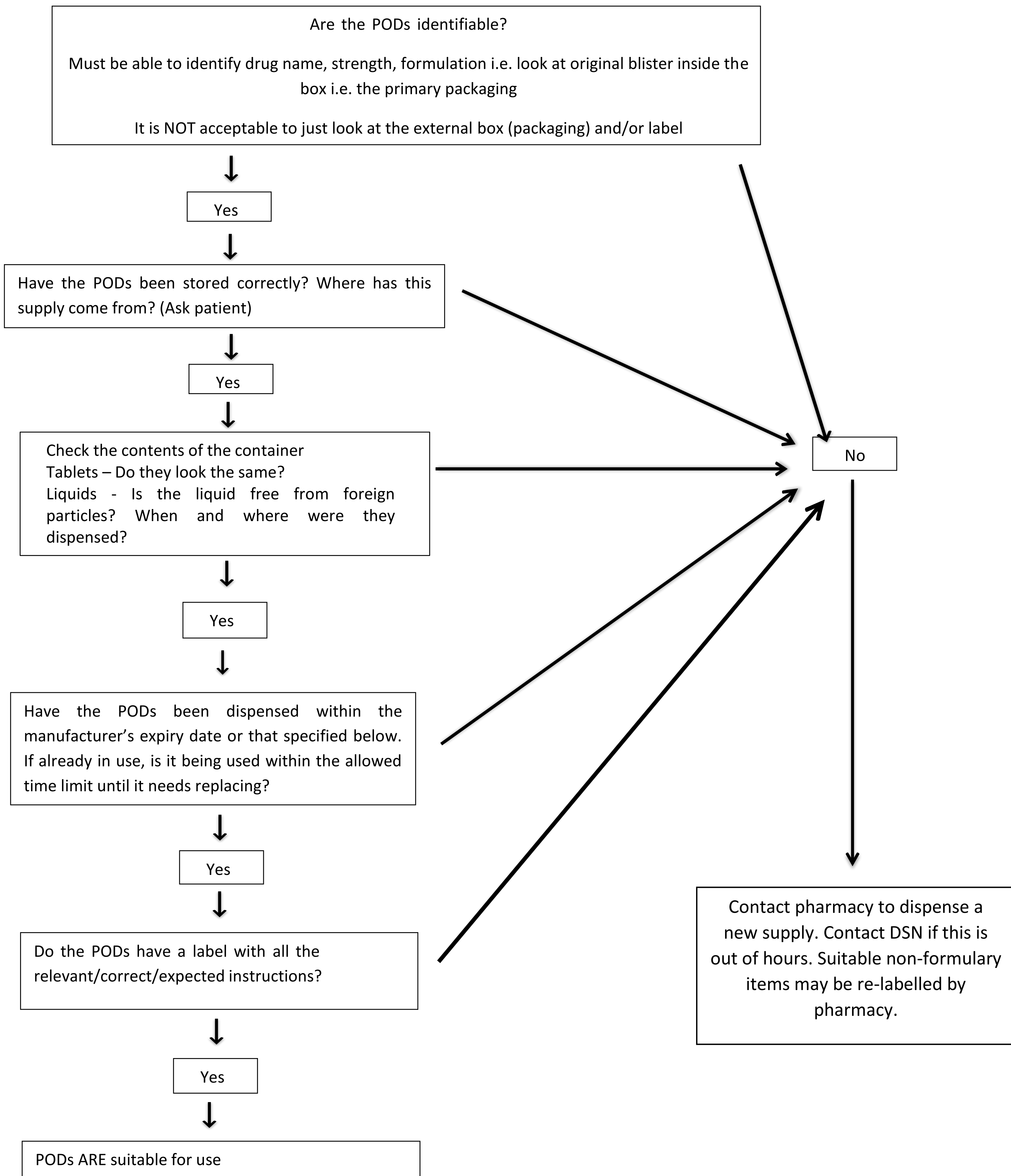
8.5 If a patient dies in hospital, the PODs will be destroyed. The only exception is when the PODs need to be retained as evidence if a medication incident is being investigated.

8.6 Any unidentifiable PODs sent to pharmacy will be destroyed. Consent will be assumed.

Appendix I Guide to handling PODs on admission



Appendix II Guide to assessing the suitability of PODs for administration



Appendix III. Suitable time limit within which PODs may be used

Preparations	Time limit for use
Oral solid doses (Tablets and Capsules)	For loose tablet/capsule within 6 months of dispensing. Check foil strip of those in a blister for the expiry
Oral Liquids	Within 6 months of dispensing or the manufacturer's expiry date (whichever is first)
Creams, ointments, lotions and other external preparations	Tubs: Opened for less than 2 months Tubes: Manufacturer's expiry date
Fridge Items	Within Manufacturer's expiry date. Patient MUST be sure item has been correctly refrigerated at all times, if not the DO NOT USE – contact Pharmacist for advice.
Eye drops and ointments: WITH eye infection WITHOUT eye infection	Opened for less than 1 week Opened for less than 2 weeks
Nose and ear drops	Opened for less than a month