POLICY FOR THE USE OF PATIENT'S OWN DRUGS

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Sept 2019
2	Review- Approved by Powys Area Prescribing Group Addition of ATO role and responsibility to policy. ATO staff now included and may perform POD medication pre checks and escalate any actions to the responsible MM Technician.	March 2024

Name	Job title and organisation	Signature	Date
Senior doctor Dr Kate Wright	Lead doctor for PTHB	DocuSigned by: Kate Wright 1F267952823F473...	8/16/2024
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ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Pharmacy professionals
Ward nursing staff
Ward medical staff

Circulated to the following for Consultation

Date	Role / Designation
April 2023	Pharmacy Team
July 2024	Senior Nurses, cascaded to ward teams

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? • Department of Health, Pharmacy in the future – implementing the NHS plan. Department of Health 2000 • The Audit Commission – A Spoonful of Sugar. The Audit Commission and Department of Health 2001. • Implementing medicines related aspects of the NSF for Older People. Department of Health 2001 • Welsh Assembly Document WHC (2202)71 Medication Supply to Hospital Patients • Your Care, Your Medicines: Pharmacy at the Heart of Patient-centered Care. RPS Wales 2013

IMPACT ASSESSMENTS

Equality Impact Assessment Summary

	No impact	Adverse	Differential	Positive	Statement
Age	X				The use of patient's own drugs is anticipated to have a positive effect on patients through continued familiarisation with preparations used. The version on the internet must be translated to Welsh.
Disability	X				
Gender reassignment	X				
Pregnancy and maternity	X				
Race	X				
Religion/ Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and civil partnership	X				
Welsh Language	X				
Human Rights	x				

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?

- The pharmacy team provide a limited Powys wide service between the hours of 9 – 5 Monday – Friday on a site rota basis and so provision will need to be made for the management of any medicines arising from the admission of a patient outside times that a pharmacy professional is available on the ward. This will be through using nursing staff to provide an assessment for short term use of medicines until they can be assessed by a pharmacy professional.
- The siting of bedside lockers for storage of medicines is under continual review as equipment requirements for wards change this may impact on the most suitable positioning of the locker.
- The maintenance/replacement of faulty bedside lockers for storage of medicines is under continual review to ensure fit for purpose equipment is available to support storage of medication at the patient bedside.

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?
Patient confidentiality of medication within Lockers identified. Opaque glass or solid fronted lockers used to redress this.

Have you identified any training and / or resource implications as a result of implementing this?

- All pharmacy technicians involved in the process will have successfully undertaken an accredited patient's own drugs assessment package and deemed competent to carry out assessments. Currently this is delivered through HEIW
- Any nursing staff involved in the process will complete a Pharmacy team delivered awareness package.

1 Policy Statement / Introduction

Powys Teaching Health Board recognises the benefits in being able to use patient's own drugs (PODs). This is where a patient brings all of their current medication with them on admission to hospital and instead of storing these medications away from them until discharge they are used for that patient (if considered suitable) during their inpatient stay.

The use of PODs is described in several key documents, the latest being an Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales. The sources include the Department of Health, RPS, Audit Commission and Welsh Government.

PODs schemes have shown many advantages including:-

- Reducing medicines related errors on admission by increasing the accuracy of Medicines Reconciliation.
- Encouraging patients to ask questions about their medication and help identify compliance/adherence and counselling issues.
- Reducing confusion by allowing patients to maintain the familiarity of their own medicines.
- Reducing omitted and delayed doses due to waiting for medicines to arrive from Pharmacy.
- Reducing waste by preventing the unnecessary re-supply of medicines.
- Allowing identification of expired and discontinued medication patients may have in their possession.
- Reducing discharge delays by having PODs available on the ward to reconcile with the discharge prescription.
- Supporting self-care by allowing progression to self-administration by patients (see Self-Administration of Medicines Policy and associated training – in development).

2 Objective

The purpose of this policy is to enable the use of PODs within Powys Teaching Health Board community hospitals.

PODs from home will be used providing they are risk assessed and confirmed to be suitable and safe and the patient has consented to use.

The policy will outline: -

- Patient selection and consent
- How PODs are assessed and identified as being suitable for use
- How to store PODs
- The process for disposing of PODs if unsuitable
- The requirement to transfer PODs if the patient is moved
- The process if doses or medicines are changed during the inpatient stay or on discharge
- The return of medicines to the patient at discharge

This policy will provide nursing and pharmacy staff with a clear framework for how the system will be managed and delivered in a safe and effective manner.

3 Definitions

- **Accredited Checking Technician (ACT)** – a registered pharmacy technician who has been deemed competent to final accuracy check dispensed medicines, which can then be given directly to the patient.
- **Medicines Management Pharmacy Technician (MM Pharmacy Technician)** – a Pharmacy Technician registered with the GPhC who has gained the Medicines Management qualification. Performs the initial check of POD's following medicines reconciliation.
- **Pharmacist** – Registered with the GPhC
- **Pharmacy Technician** – Registered with the GPhC. Can check POD's (excluding initial check), order POD's.
- **Assistant Technical Officer (ATO)** – also known as Pharmacy Assistant - a non-registered member of pharmacy staff who may be trained to be competent to deliver a number of pharmacy tasks under the supervision of a pharmacy technician or pharmacist.
- **CDs-** Controlled Drugs
- **Clinical Trial Medication** – medication supplied to a patient who is enrolled into a clinical trial.
- **ePMA-** electronic Prescribing and Medicines Administration
- **GSL medicine-** General sales List
- **MAR Chart- Medicines Administration Record -** used to support carers in administering medication in the community
- **MM -** Medicines Management
- **Monitored Dosage System (MDS)** – also known as Multi-compartment Compliance Aids (MCCA, or MCA), Dosette Boxes, Blister packs, Medidose or Venalink. This is a device into which medicines are dispensed into separate administration times for each day.
- **MTeD** – Medicines Transcribing and electronic Discharge system. An All Wales system that allows an electronic communication of a PTHH discharge to the GP practice.
- **One Stop Dispensing or Dispensing for Discharge** – medicines supplied to an inpatient as a complete patient pack, labelled with directions, to cover the inpatient stay, periods of leave and discharge.
- **Parallel Import** – Occasionally pharmacies may obtain medicines from different countries, for example if there are supply shortages in the UK. In the case of products where the packaging is in a different language, a sticker must appear with full details in English. An English language patient information leaflet must also be supplied.
- **Patient's Own Drug (POD)** – is a medicine that has been individually dispensed for a named patient. Medicines brought into hospital by the patient are PODs and any medicines dispensed by the hospital pharmacy labeled with instructions for a named patient are also PODs.
- **PTHB** – Powys Teaching Health Board
- **P Medicines-** Pharmacy Medicines available to purchase from pharmacies when pharmacist is present only

- **Supplying Pharmacy** – where stock medicines are supplied from to PTHB wards. Different arrangements may apply for non-stock medicines and discharge medication.
- **TTO** – 'to take out' is a common abbreviation for a hospital discharge prescription and the subsequent medication pack supplied for discharge.
- **Dispensing of medication** – selection and labelling of medication using suitable reference source (medication chart/ TTO/ prescription). May be performed by pharmacist/ technician/ competent ATO. May be checked by pharmacist/ ACT qualified technician. *NOTE Dispensing and checking of a medication should not be performed by the same person*- link to labelling policy
- **Assembly of medication**- collation and 'bagging up' of medication including relevant paperwork ready for supply at discharge. May be performed by pharmacist/ technician/ competent ATO. May be checked by registered nurse (if assembled by pharmacist only) pharmacist/technician/ *NOTE assembly and checking of assembled medication should not be performed by the same person.*

4 Responsibilities

Medicines Management Pharmacy Technician – the MM pharmacy technician will be responsible for the day to day management of the PODs scheme for allocated wards, including the initial suitability assessment of PODs (including new patients with an interim assessment by nursing staff). The pharmacy technician will be able to re-label PODs and stock medicines, order and label additional items to supplement the PODs available and assemble medication/check assembled medication ready for discharge against a TTO clinically checked by a Pharmacist.
If currently qualified as an ACPT the pharmacy technician will be able to provide a final accuracy check for medicines dispensed by another pharmacy technician, pharmacist or competent assistant technical officer.

Pharmacy Technician – the (non MM) pharmacy technician will be responsible for the ongoing day to day management of the medication stored within the POD locker, but not the initial suitability assessment. The pharmacy technician will be able to re-label PODs and stock medicines and order and label additional items to supplement the PODs available.
If currently qualified as an ACT the pharmacy technician will be able to provide a final accuracy check for medicines dispensed by another pharmacy technician, pharmacist or competent assistant technical officer.

Pharmacist – the pharmacist will provide clinical support and advice and clinically check the suitability of medicines prescribed for inpatients and on discharge. The pharmacist can provide the final check to medicines dispensed for discharge by the pharmacy technician or ATO and can assess the suitability of PODs in the absence of the pharmacy technician. The pharmacist may also, if necessary, dispense medication/ and assemble/ check assembled medication ready for discharge.

Registered Nurse – the registered nurse will be responsible for safely administering medicines from the bedside locker or PODs trolley and ensuring the security of the bedside PODs locker and PODs trolley at all times.
The registered nurse must ensure that PODs are appropriately transferred from the assigned bedside locker if the patient is moved from or around the ward and that lockers or PODs trolley draws are cleaned between patients.
The registered nurse can assess PODs for short term use out of hours and at weekends within the remits of this policy. If suitable these medicines must have a blue assessment sticker attached and be placed in the PODs locker or PODs trolley. New patients should be referred to the pharmacy technician or pharmacist when they next attend the ward. Registered nurses may also perform the second check when medication is being assembled ready for supply to the patient, by a pharmacist only at discharge.

Assistant Technical Officer (ATO) – if signed off as competent the ATO may re-label PODs or stock items for use on the ward or for discharge under the direction and supervision of the pharmacy technician or pharmacist. They may complete POD locker supplementary checks as delegated by a Pharmacy technician/ Pharmacist (see ATO supplementary POD locker checks appendix A)

Medicines Management Team – the Medicines Management Team will be responsible for keeping this policy up-to-date, ensuring the training and competency of all staff involved in implementing this policy and will provide advice and support to the hospital teams as necessary.

Care Transfer Co-ordinator – should ensure the transfer of a labelled supply of medicines for the patient from the DGH, including any patient's own medicines.

5 Process

All consenting patients can be included in the scheme provided their medication complies with the suitability criteria following assessment. Patients should be encouraged to bring all their medication with them upon admission.

Local DGHs that transfer patients are asked to make a full supply of labelled medicines on discharge/transfer, which may include PODs.

There is local agreement in place that our supplying pharmacies (Nevill Hall and Bronglais hospitals) will transfer patients with a full supply of labelled medicines (including PODs). They are requested to send these medicines in PODs bags.

Welsh & West Midland Ambulance services operate a green bag system and will use them to ensure medicines are brought into hospital accompanying the patient. Further information may be found at the Your Medicines Your Health website

https://ymyh.org/campaign/
If a patient is admitted without their own medication then, where possible, their relative or carer should be encouraged to bring the medication in.

A patient information leaflet is supplied (appendix B) to support patient understanding of the benefits of using their own drugs.

PODs are regarded as patient property and therefore consent must be obtained from the patient for use of their medicines during their hospital stay and to destroy any medicines no longer required. Patients should be assured that they will be supplied with at least 7 days (ideally 14 days) worth of medicines on discharge from hospital if their own medicines are used. Information will also be sent at discharge to their GP and their community pharmacy to inform of any medication changes.

Until assessed as suitable for use, by a Pharmacy Professional or registered nurse, PODs medication should be stored in the identified central PODs cupboard on the ward.

The following describes the process to follow.

5.1	**Assessment of PODs** When patients bring their own medication into hospital they need to be assessed for suitability for use and appropriateness to the patient's current prescription. An MM pharmacy technician or pharmacist will normally undertake the initial assessment of PODs. In the absence of the pharmacy professional e.g. not scheduled, out of hours, at weekends or bank holidays a registered nurse may undertake the assessment of a POD (this will be an interim assessment for new patients) to establish suitability for use. **A registered nurse should only undertake this task if the pharmacy professional is not available.** The registered nurse undertaking the POD assessment should use the checklist in appendix C as an aid. Any POD assessment undertaken by a nurse for new patients will be considered an interim assessment and the PODs must be reassessed by a pharmacy professional at the earliest opportunity. Re-stocked labelled medication for the PODs locker or trolley from Nevill Hall or Bronglais hospital pharmacy only needs to be assessed by either a registered nurse or pharmacy professional and the designated sticker applied. There is no need for a double check for this medication. **Where there is any doubt that a POD is suitable to use - stock medicines should be used, in their place or; if not available, a supply obtained from pharmacy.** This may require obtaining the medicine from pharmacy through use of blood bikes or a taxi if the normal pharmacy transport run has been missed. Care should be taken when looking through patient's own drugs that there are no sharp or contaminated items within the packaging, particularly if the patient

	is prescribed injectable items, such as insulin. The contents of the patient's own drug package should be tipped out into a tray and carefully checked.
	
	See Flowchart for the Assessment of PODs appendix D
	
	STEP 1 – Obtain Consent and Provide Patient Information Leaflet
	Obtain consent from the patient to use their own medicines - as in section 5.2. Provide the patient with a copy of the PODs scheme patient information leaflet and explain about the scheme.
	
	STEP 2 – Compare the POD with the inpatient medication chart
	A POD must only be used if the drug is currently prescribed on the inpatient medication chart or ePMA record.
	
	Any discrepancies should be checked with the prescriber to ensure that they are intentional.
	
	Any POD confirmed with the prescriber as intentionally not prescribed must be kept in the agreed central ward PODs cupboard for the pharmacy professional to review.
	
	Where there is a dose or frequency change on the inpatient medication chart or ePMA record, and consequently a discrepancy with the label, the POD should only be used if there is no easy access to replacement stock medicine. **In all cases it is the dose or frequency stated on the inpatient medication chart or ePMA entry that applies and not that on the POD label**. The pharmacy professional will re-label with the correct details when they next attend the ward.
	
	STEP 3 – Assessing the medicine
	For nursing staff undertaking an assessment of PODs the checklist appendix C should be used as an aid. Any completed checklist should then be placed in the patient's notes.
	
	The following must apply in order for a medicine to be deemed suitable for use:
	
	• Medicine containers must be clearly labelled with: -
	  ○ Name of the patient (this must be the same as the patient admitted)
	  ○ Name and strength of drug
	  ○ Instructions for use
	  ○ Date dispensed
	  ○ Expiry date (see reduced expiry date guidance)
	  ○ Name and address of supplier
	• Medicine, container, and labels must be in good condition, clean and dry.

	• Medicines must be within their expiry date (dispensing label or original manufacturer's). Note: expiry dates may be reduced for some medicines once opened e.g. some eye drops, liquids or ointments etc. as identified on the packaging or package insert. This reduced expiry should be written on by the member of staff who first opens the medication. • Containers must not hold more than one type of drug. • Non blister strip medicines not in their original container (e.g. tablets and liquids in amber or white pharmacy bottles) should not be reused unless advised to do so by a pharmacy professional, which may require contacting the on-call pharmacist. • Blister strip medicines must be clearly identifiable as the medicine and strength that the outer packaging and labelling suggests. • Blister strips of tablets of capsules, contained in non-original dispensed boxes (e.g. white containers) labelled for the patient may be used if they are identifiable and match the label and an expiry date can be found on the blister strip. • Opened eye or ear drops should only be used if the date of opening is clear, and are valid for use for up to 28 days (or shorter if advised by manufacturer) in a hospital environment. A fresh supply will be made on discharge. • For 'Over the Counter' preparations – can be used if authorised on the inpatient administration chart – stock supplies should be used and a new labelled supply (this can include the manufacturer's instructions for P or GSL medicines) should be obtained from the pharmacy team as appropriate. The 'Over the Counter' medicines will be kept in the central PODs cupboard or destroyed (with consent) as appropriate. Out of Hours the on call pharmacist should be contacted for advice. See PTHB Medicines Policy MMP001 • Medication that is suitable for removal from the refrigerator when in use should be stored in the PODs locker but must be annotated with reduced expiry if appropriate. In the rare event that a patient is admitted with a clinical trial medication it may be necessary to contact the trial investigators for information on whether the item should be continued – the ward pharmacy team should be contacted for advice. **STEP 4** – **"approved for use sticker"** Two different colours of sticker will be in use. • Pharmacy technician or pharmacist assessment – green sticker • Nurse assessment (interim for new patients) – blue sticker If the assessment deems the POD is suitable for use apply the appropriate sticker. • The assessor should initial and date the sticker.

- Ensure the sticker is not obscuring any important information on the medication container.

If a pharmacy professional is not the original assessor for new patients they will carry out their own assessment and apply a green sticker across the top portion of the blue sticker if in agreement about suitability for use.
The pharmacy professional will also endorse the quantity available on the date of assessment.

STEP 5 – **Store the medicines appropriately**

- For medicines deemed suitable for patient use – place in patient PODs locker or in the PODs trolley.
- For duplicate supplies of medicines – the second or subsequent packs of medicines should be stored in a green bag in the PODs locker or PODs trolley (if space allows) or central PODs cupboard. This is to keep it clear which are 'in use' medicines and reduce the risk of confusion.
- Some medicines have specific storage requirements – see section 5.3.
- For medicines that are not prescribed, deemed not suitable for use or if there is doubt – store in the agreed central ward POD cupboard for review by the pharmacy professional.

STEP 6 – **Additional Medicines**

- Any additional medicines required can be added to the PODs locker from the stock medicines cupboard. When possible these additions will be appropriately labelled. All medication must be labelled in preparation for discharge or the patient starts self administering their medicines (see separate self administration policy, in development) when they must be labelled.
  The appropriate blue or green 'approved for use' sticker must be initialed, dated and applied, when adding stock medicines to the PODs locker.
- PODs wards will have a selected supply of P or GSL legally classified medicines e.g. small packs of analgesia – these have clear directions for use on the original packaging, but do not have space for a patient's name. They also have a pharmacy address label sticker from either Nevill Hall or Bronglais pharmacies. There should be a [P] on the box for a pharmacy medicine and there may be [GSL] for general sales list medicines.
  These medicines may be included in the PODs locker or PODs trolley. The appropriate blue or green 'approved for use' sticker must also be initialed, dated and applied.
- Any medicines that are prescribed and are not ward stock and not available as PODs medicines may be ordered from the supplying pharmacy. The pharmacy team may order using PODs order form or pharmacy order form (available from MTeD) emailed to the supplying pharmacy. A copy of the inpatient medication chart or ePMA record to enable a clinical pharmacy check by the supplying pharmacy will be

required if the item on the chart has not been clinically checked by a PTHB pharmacist.
If the pharmacy team are not available then ward staff can order via email, including a scanned in copy of the inpatient medication chart or ePMA record to enable a clinical pharmacy check and supply of the item for the patient.

NB
To avoid potential patient harm by omittance of newly prescribed medication-
If the patient requires a non- stock item before the pharmacist is onsite and able to clinically check the new medication then a Pharmacy Technician may order that item from the supplying pharmacy but include a copy of the inpatient medication chart or ePMA record for the item requested to be clinically screened by the supplying pharmacy pharmacist before being issued.

Monitored Dosage Systems (MDS)
Because in many cases it would be difficult to confirm the identity of each loose medicine contained within a MDS with absolute certainty – MDS should not be used to administer drugs to inpatients. Until the pharmacy team are available stock items should be used, this may require obtaining the medicine from pharmacy through use of blood bikes or a taxi if the normal pharmacy transport run has been missed. The pharmacy team will arrange a supply for the PODs locker or PODs trolley at the next available opportunity.

MAR Charts
Original packs of medicines supplied with MAR charts may be used during the inpatient stay if deemed suitable on assessment. The patient will require a fresh MAR chart and supply of medicines on discharge if still appropriate for level 2 medication administration. These will be arranged by the pharmacy team as part of discharge planning.

Controlled Drugs (CDs)
If a patient brings their own controlled drugs into hospital they can be assessed (as above) and reused if suitable. All schedule 2 & **some** schedule 3 controlled drugs, will however, need to be kept in the ward Controlled Drugs cupboard and not the patient's locker or in the PODs trolley.

- The item will also need to be entered into the ward CD register and witnessed. A registered nurse, pharmacy technician or pharmacist may be a witness to any required PODs CD entry into to the register.
- Where a PODs CD register is not in use, it is suggested that a separate page at the back of the ward stock controlled drug register is used for each patient CD – this will allow a running record of administration.
- Note: morphine sulphate solution **10mg/5ml** strength only (e.g. oramorph) is classified as a schedule 5 CD and so can be stored in the PODs locker or the PODs trolley.

	• Gabapentin, pregabalin and tramadol have been reclassified as schedule 3 controlled drugs but do not require CD cupboard storage and can be kept in a POD locker. **Recording the use of PODs on the Inpatient Medication Chart or ePMA record** When a patient's own supply of medicine is being used during an inpatient stay, this should be recorded on the inpatient medication chart or ePMA record by the pharmacy professional. The pharmacy professional will endorse the relevant medication entry by writing "POD" in the pharmacy box. This will ensure that everyone involved with the supply of medicines is aware that the patient is using their own supply. The pharmacy professional will also annotate 'stock' in the pharmacy box if a stock medicine (located in the ward medicines trolley or medicines cupboard) is to be used. For paper charts a pharmacy technician will annotate in red pen and pharmacist with green pen.
5.2	**Consent** PODs are the property of the patient and therefore consent for their use should be obtained – see appendix E for consent form. Verbal consent is acceptable, and the pharmacy professional should document that this has been obtained. If the patient does not want their own medication to be used during their inpatient stay then they can nominate someone to collect it from the ward. Or it may be stored in the designated central PODs cupboard on the ward. It may be helpful to remind the patient that they will be given at least 7 days (ideally 14 days) supply of medicines on discharge and to give them a copy of the patient information leaflet. The patient does not need to consent to this but the registered nurse/pharmacy professional should sign appendix E to say that this has occurred. The patient needs to consent to a medication being destroyed in accordance with section 5.5. Preferably patients should sign the consent form (appendix E) and the registered nurse/pharmacy professional witness, but a verbal consent is acceptable. The nurse/pharmacy professional should document verbal consent obtained. Where consent is refused or not able to be given and the medication considered to be a risk to the patient, the pharmacy professional should use their professional judgement whether to destroy the medication. It may be necessary to discuss further with the multidisciplinary team or relatives or carers. If it is considered that it is in the best interests of the patient to destroy the medicine, then this may be done without consent. Full documentation of the reasoning and any discussions had must be clear in the patient's notes.

5.3	**Storage of PODs** PODs will be stored in the designated white metal wall locker that is located at or near each patient bedside. In mental health wards PODs will be stored in a designated PODs trolley which has separate compartments, or draws, for each patient. With the exception of: • Items requiring refrigerated storage, which should be stored in the ward medicines fridge. Remember 'in use' insulin, GLP1 agonists and some eye drops should/can be kept at room temperature, although for a limited time. Refer to manufacturers SMPC (www.medicines.org.uk) or a pharmacy professional for advice. • Schedule 2 and some schedule 3 controlled drugs should be stored in the ward CD cupboard • Drugs given by injection (except insulin & GLP1 agonists which may be suitable for self administration) should be stored in the medicines trolley or ward medicines cupboard • "once only drugs" should be stored in the medicines trolley or ward medicines cupboard • "as required" night sedation that the patient did not take before admission should be stored…… (note temazepam must be stored in the CD cupboard). • It may also be necessary to store "bulky items" in a ward medicines cupboard or trolley if they do not fit into the PODs locker or the PODs trolley. A risk assessment should be undertaken with regard to medicines such as salbutamol inhalers or GTN sprays, that need to be easily accessible and where they should be stored. The risk assessment should factor in the needs of patient, the ability of the patient to keep safe and any risk issues with surrounding patients. Accessible medicines should be kept out of sight and if deemed suitable can be stored in the unlocked non-PODs bedside locker. **If a patient is moved within the ward the registered nurse responsible for the patient move must ensure that any PODs are moved to the PODs locker (and within the PODs trolley if necessary) at the new patient location.** **Pharmacy PODs Locker or PODs Trolley Checks** The MM pharmacy technician will co-ordinate a schedule of PODs locker or trolley checks to ensure that at least 14 days worth of medication is kept in the locker or trolley. These checks may be completed by MM technician, pharmacy technician and if not available, the ward pharmacist. ATO staff may contribute to this process by completing a supplementary PODs check (appendix A) The ward pharmacist, nurse and doctor must ensure that the pharmacy technician is notified of any dose or medication changes, so that medication in the PODs locker or trolley can be kept up-to-date.

Digital Lock
The PODs locker has a digital code lock, with a unique code for each individual locker, 3 options for a master code for each ward and a manufacturer default code. Codes can be obtained from the ward pharmacy professional or the medicines management team who have site plans with codes for each locker.
Only in accordance with a self administration policy may the patient be given the access code to their locker.

If there is any concern that a patient or me mber of the public has got hold of the code to a locker that is not theirs, then the pharmacy professional or medicines management must be requested to come and change the codes as soon as possible.
The ward senior nurse must risk assess the situation and it may be decided that the respective locker medicines need to be moved to the ward drug trolley or medicines cupboard until the code is changed.

Staff must make every effort to keep locker codes confidential

When opening – the digital lock handle needs to be lined up vertically, to allow the lock to open efficiently. Any problems with opening PODs lockers should be referred to the Pharmacy or Medicines Management teams.

Digital lock batteries – the batteries for the digital locks should last 10000 uses and are on a rolling program for replacement. The digital lock will signify when the battery is running low by two flashing red lights from 1000 door openings left. Estates or the ward pharmacy team must be requested to replace the batteries. Supplies of batteries are available by emailing the Medicines management Team
info.medicinesmanagement.powys@wales.nhs.uk to request .

In the unlikely event that the digital lock fails your ward pharmacy professional will have advised the ward on a method for opening the locker – a method which should be kept confidential to professional staff. The ward pharmacy professional or medicines management team must be informed if this action has had to be taken, so that it can be ensured that the digital lock can be looked at.

PODs Trolley Keys
The individual PODs trolley keys for each draw/compartment must be kept in a secure locked location which can only be accessed by a registered nurse or pharmacy professional (e.g. medicines cupboard) until any self administration policy comes into use on the ward.

It is the master key (individual key that opens all locked draws) that will normally be used for administration by the registered nurse.

	The master key must be held by a registered nurse, when not in use, or when administering or by the pharmacy technician, ATO or pharmacist when checking or topping up the PODs trolley. **Cleaning lockers or PODs trolley draws** – the registered nurse will be responsible for ensuring the cleaning of the PODs locker or trolley draw between patients, in accordance with the current PTHB infection control policy.
5.4	**Administering PODs** The registered nurse must administer all medicines in accordance with Powys THB Medicines Policy and the standards outlined in the RPS/NMC Medicines Administration Guidelines. Even though the medicines are contained in the PODs locker or individual draw with the PODs trolley, the same standard of checking that the right medicine, of the right strength, at the right dose, by the right route, for the right patient, is selected, still applies. This also includes checking that the strip of medication in the medication box contains the medication as stated on the labelling of the box. Care must be taken to check expiry dates on medication, especially those that should have a reduced expiry once opened (see reduced expiry guidance sheet). The medication chart or ePMA record will have been endorsed "POD" by the pharmacy professional to indicate if a POD is available, if so, this medicine will be available in the PODs locker or on the PODs trolley. If there is no endorsement the medicine may be in the PODs locker or PODs trolley, if this is the case and a "approved for use" (green) or "temporarily approved for use" (blue) sticker is applied this medicine may be used. If there is no "approved for use" or "temporarily approved for use" sticker then the administering nurse must undertake the assessment outlined in 5.1 or otherwise use stock medication if available. If the medication has been endorsed by the pharmacy professional as 'stock' then this will either be available in the medicines trolley (frequently used medicines e.g. laxatives or analgesia) or in the ward medicines cupboard. **Named patient PODs must only be used for the patient whose name appears on the label. Under no circumstances must the medicine be used for another patient.**
5.5	**Disposing of PODs** PODs should be discarded (with consent see 5.2) if: • They are not readily identifiable • The expiry date (including shortened opened expiries) has been exceeded • The medicines, labels and/or containers are in poor condition

	• Any items requiring cold or special storage if there is concern about their storage history • They are no longer prescribed for the patient and there is no suggestion that the medication may start again at a later date and the requirements for consent are fulfilled (see section 5.2). Medication should be disposed of on the ward in the appropriate pharmaceutical waste bin in accordance with PTHB pharmaceutical waste procedures. Consideration should also be given to disposing of medication that has been deemed not suitable for use on assessment, in accordance with the consent section (5.2). If there is the possibility that the medication may restart at a later date then the medication should be stored in the agreed central ward PODs cupboard.
5.6	**Transfer of Patients – within a ward or to other PTHB wards** The registered nurse must ensure that PODs are appropriately transferred from the bedside locker or PODs trolley, as appropriate when the patient is moved from or around the ward.
5.7	**Medication or Dose Changes – re-labelling** Only a trained pharmacy team member may label new medication started for a patient or re-label PODs for a dose change (see Pharmacy Medicine Labelling Policy). A pharmacy technician or ATO will only be able to label new medication or re-label any dose changes once a pharmacist clinical check has taken place. If there is a delay then it is possible that the label on the medication may not match the inpatient medication chart or ePMA record directions. **In all cases it is the dose or frequency stated on the inpatient medication chart or ePMA record that applies and not that on the PODs label**. Any re-labelling of a medicine must not obscure the original supplying pharmacy/dispensary name and address details which must be left in view. **Nursing staff must not label, re-label or alter medication labels in any way, although they may provide a 2nd check to medication labelled by a Pharmacist.**
5.8	**Discharge of Patient** All PTHB discharges should be planned well in advance – allowing at least 3 working days for medication orders. *See separate M*edication Discharge procedure (link to be added)*.*

	The medical team will need to prepare TTOs in the normal way (either handwritten or electronically through MTeD) and this forms the legal prescription for the supply of medication on discharge. In many cases the pharmacy team will be able to provide discharge medication directly from the ward. This is a process known as 'One Stop Dispensing' or 'Dispensing for Discharge'. Utilising PODs or labelling ward stock medicines as needed, with at least 7 days supply of medicines issued on discharge, ideally a minimum of 14 days will be supplied. The pharmacy professional may make a professional decision around making less than 7 days supply at discharge if they are absolutely confident that there are sufficient supplies at home of any unchanged medication. **Any discussion around this should be clearly documented in the patient's notes**. The pharmacy team will re-label any dose changed PODs and label any new medicines. Pharmacy professionals may collate any pre-dispensed items that match the TTO ready for discharge without the need for a second check. However, if any items have been re labelled or newly dispensed at ward level these will need to be second checked by an ACT qualified pharmacy technician or pharmacist. **Under no circumstances must a patient be sent home with un labelled (except for P or GSL medicines) or incorrectly labelled items**. If a dose is changed or a new medicine added after the TTO has been prepared, then the pharmacy professional should be contacted by phone for advice on this. If the pharmacy professional is not available then the TTO along with a copy of the medication chart or ePMA record should be e-mailed to pharmacy for the new item or replacement item to be dispensed. Any incorrect medication must be removed from the previously prepared discharge medication. If the pharmacy professional is not available at the time of discharge then the registered nurse discharging the patient must check that any medicines issued to the patient match the latest TTO prescription. Checking and assembling these already labelled medicines does not constitute dispensing.
5.9	**Stock & Non Stock Ordering with PODs scheme in place** For wards operating a PODs scheme there will be a full review of the ward stock list, in agreement with the ward manager, to take into account the change in administration of medicines. Stock drugs will be continue to be ordered in the normal way, but it is anticipated that quantities and range of drugs required will be reduced.

	Non-stock drugs should ideally be ordered by a pharmacy professional, using the agreed process and medicines will be labelled with directions. If the pharmacy professional is not available then nursing staff should order from the supplying pharmacy providing a scanned copy of the inpatient medication chart or via EPMA record to to enable labelling of the item for the patient.
5.10	**Returning Medicines to Stock** In specific circumstances medicines previously supplied to the PODs locker or PODs trolley that are no longer required may be returned to stock. The specific requirements are:- • The medicine must have been supplied to the ward by Nevill Hall or Bronglais hospital pharmacy. • The medicine is not a controlled drug requiring CD register entry. • The medicine must not have left the ward. • The patient to whom the medicine were allocated must not have suffered an infectious disease or have been barrier nursed for any other reason. • The patient has not had access to the PODs locker or the PODs trolley draw and all medicines have been administered by the registered nurse. • The pharmacy professional must assess the medicine to check it is suitable for use. If it is then ensure all labels relating to the previous patient are removed and add a yellow “returned to stock” sticker, initial and return to stock.

6 Monitoring Compliance, Audit & Review

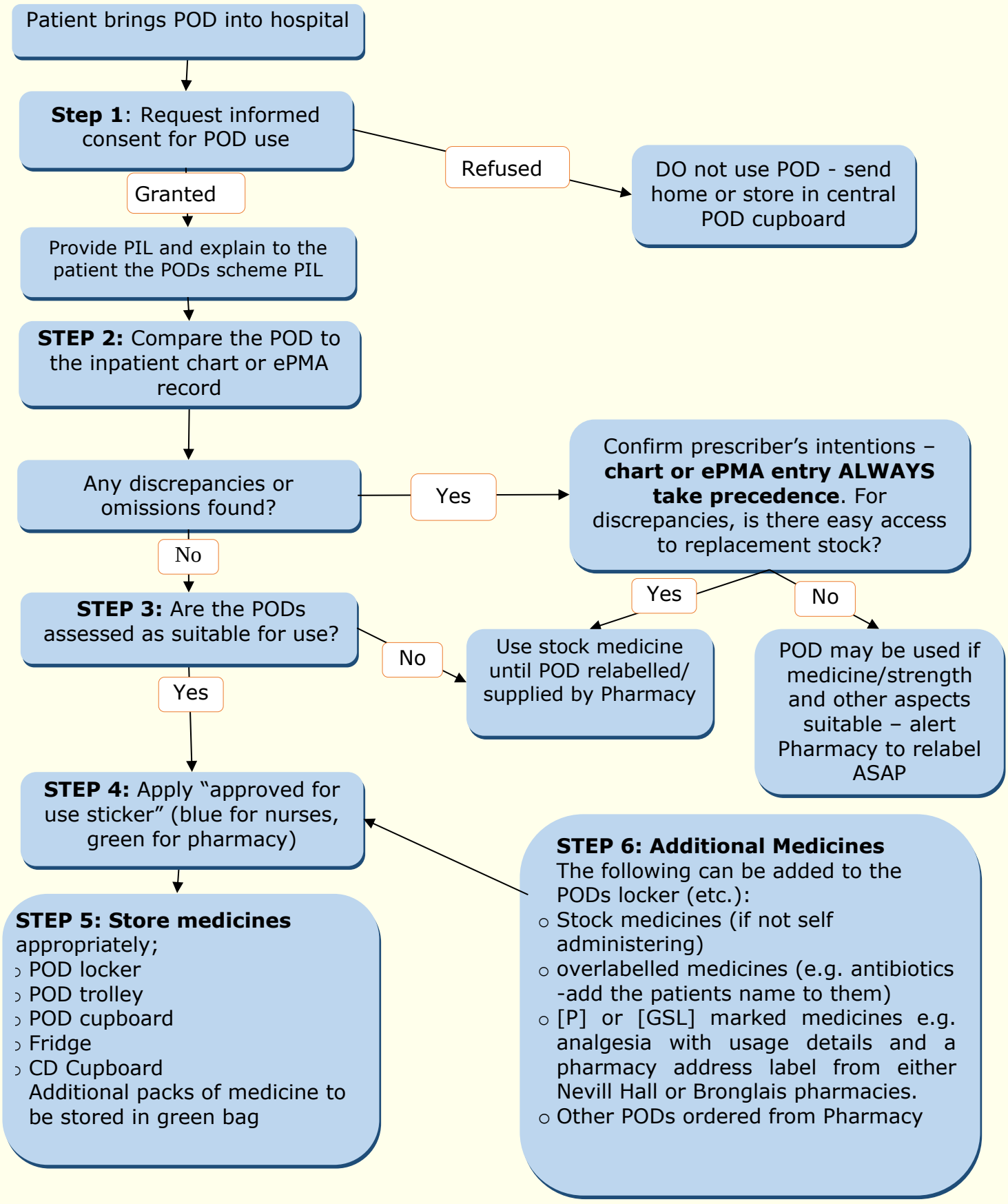
Audit of compliance with this policy will be undertaken annually.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise. *(standard statement that can be amended to fit if your document is to be reviewed earlier)*

7 References / Bibliography

- RPS Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales https://www.gov.wales/review-clinical-pharmacy-services-nhs-hospitals-wales
- Pharmacy delivering a Healthier Wales
- RPS/NMC administration guidelines
- Your Medicines Your Health

Appendix D



Attach addressograph label:

Patients Name:……..

Hospital Number:……...

D.O.B:……..

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Appendix C - Assessment Form for use of Patients Own Drugs

This form should be used by **NURSING STAFF** and filed in the patient's notes

ALL medication brought in by the patient MUST be assessed and MUST be prescribed before administration.

Tick (ü) if medication meets stated criteria

Criteria / Name of Medicatio												
The medicine is currently prescribed on the in-patient chart or ePMA record												
• The POD has the correct patient name on the label • The label on the container is clear, typed and correctly identifies the contents, the dose & frequency of administration												
The medicine is supplied as:- • tablets or capsules in original strip pack cartons or official white pharmacy cartons. • an inhaler • A liquid, tube cream or ointment, eye drops or ointment, nose drops or sprays, ear drops or vials or cartridges of insulin where there is assurance about the date of opening.												
The name of the drug on the label matches that on the packaging and the blister strip, inhaler or tube of ointment/cream												
There is only one product per container.												
The POD is supplied in a recognised medicine container which is clean and dry and there is no sign of deterioration.												

The POD has not passed the manufacturers expiry date or any reduced open/in use expiry date.												
Can reasonably assume that the medicine has been kept within recommended storage conditions. E.g. stored in a refrigerator.												

Only use medication if it meets ALL criteria above (i.e. all boxes are ticked). If in doubt seek advice from your ward pharmacy technician or pharmacist and use ward stock or order a new supply from Pharmacy in the meantime.
I have assessed the patient's medication as suitable for use on the ward and attached and initialled an "Approved for Use" (blue) sticker to each container

Signature of Assessing Nurse…….

Name (Block Capitals)…….

Date……

Appendix B
Patient Information Leaflet – copy of text from leaflet. Leaflets to be supplied to ward

Information for Patients on Use of Your Own Medicines during your Hospital Stay

We would like to use your own medicine supplies during your stay in hospital. This is to ensure there is no delay in supply of your medication and to reduce waste in the NHS. Your medicines will be stored in an individual locker close to your bed, or in a designated draw within a medicines trolley and the nurses will use them when administering medicine to you throughout your stay.

Your medicines will only be given to you; they will not be used for any other patient.
If your supplies run low or new medicines are prescribed then we will supply new medication to you.
What this means to you:-

- When you come into hospital please bring all the medicines you are currently taking with you in their original containers. This includes:-
    - Tablets and capsules
    - Liquids
    - Creams or ointments
    - Inhalers (puffers)
    - Any other items from your GP (your family doctor)
    - Any items you buy from a pharmacy
- A pharmacy professional or nurse will assess your medicines to check that they are suitable to use. They will also check the labels to make sure that they have the right instructions.
- The ward staff may ask to remove medicines if:-
    - They are no longer used for your treatment or
    - They are not of good quality or
    - They are not clearly labelled with instructions

If it is decided to remove medicines the pharmacy professional or nurse will tell you why. They will also need your consent to take them away to dispose of them. This is to prevent any confusion about the medicines and minimise any risk to patients.

If we take away a medicine because you are no longer prescribed it and you have more of that medicine at home, you should take it to your community pharmacy/GP dispensary for correct disposal.

When it is time for you to go home:-

- We will make sure you have a minimum of 7 days supply to take home.
- You may end up taking home some of your own medicines and some medicines supplied by the hospital.

If you have any questions about your medicines during your stay please ask the pharmacy professional or nurse.

Pharmacy professionals will identify themselves to you and may be wearing an aqua-green colour uniform detailed with a pharmacy cross.

Never share your medicines with anyone else when in hospital or at home.

Appendix E
PATIENTS OWN DRUGS SCHEME
Authority for Use/Return or Destruction of PODs

Patient name and address:	
Hospital:	Ward:
Date admitted:	

1. **Consent to reuse Patient's Own Drugs**
   I agree to the use of my own medicines for MY treatment during my stay in hospital. I understand that I will be provided with necessary supplies upon my discharge from hospital
2. **Consent for the Destruction of Patient's Own Drugs:**
   Where informed the medicines you have brought into hospital are not suitable for re-use within the hospital and are also inappropriate for you to use in the future it may be necessary for these drugs to be safely disposed of

   I understand my medicines may have to be destroyed and agree to Powys teaching Health Board arranging this.
3. **Return of Patient's Own Drugs:**
   The medicines you have brought into hospital may be assessed and we may unfortunately be unable to use them during your stay.

   The drugs will be placed in a bag and either:-
   Returned home with your nominated person.
   OR
   Stored in a locked cupboard on the ward. This cupboard will not be accessible to you.

Please remember to ask for any stored drugs to be returned to you when you are going home.

Mark "verbal consent" if obtained:-

Patient signature…….Date……

Signature of Nurse/Pharmacy staff witnessing agreement to above

RETAIN IN PATIENT NOTES DURING STAY
Appendix A

Supplementary POD checks by ATO staff

Where appropriate the pharmacy professional may delegate a supplementary POD check to be carried out by ATO staff. This should be used as a pre/ interim check to aid in identifying any potential issues regarding medication contained within a POD locker. It is not the responsibility of the ATO to resolve any discrepancies, but to escalate to the appropriate Pharmacy or healthcare professional to action, although the ATO may then be requested, by the registered professional to perform additional tasks within their scope of practice relating to the check.

Process

1) The ATO will discuss with the ward-based pharmacy? team which POD lockers need to be checked that day. This is to avoid duplication of work.

2) The ATO will assess 1 POD locker at a time.

3) The ATO will obtain the patients medicine chart or ePMA record, and, following the order in which the medicines are prescribed, remove each item from the locker one by one and check that-

- each medicine has received a pharmacy check – and that each medicine has a completed green sticker on it.
- Identify any items missing.
- Identify any items with less than 14 days supply remaining.
- Identify any item within the POD locker that is not on the chart or ePMA entry.
- Document anything found on the **ATO Record of Locker Checks form**.

4) Once the ATO has completed all the locker checks allocated to them, they should hand over the completed ATO Record of Locker forms to the Pharmacy Professional onsite to enable them to take the appropriate action

In the absence of a Pharmacy professional a member of the nursing team should be given the form to take any interim actions required, always ensuring that the Pharmacy Professional has sight of the completed form when next onsite.

ATO Record of Locker Checks form					
DATE OF CHECK:	PT INITIALS:	BED NO:	ATO INITIALS:	TECHNICIAN/ PHARMACIST INITIALS:	
Medication name/strength form:					
Nature of Discrepancy (tick below appropriate heading)-	Green Sticker Missing	<14 Days Supply Remaining	Missing from Locker	In Locker but not on Inpatient Chart or ePMA entry	Comment s
DATE OF CHECK:	PT INITIALS:	BED NO:	ATO INITIALS:	TECHNICIAN/ PHARMACIST INITIALS:	
Medication name/strength form:					
Nature of Discrepancy (tick below appropriate heading)-	Green Sticker Missing	<14 Days Supply Remaining	Missing from Locker	In Locker but not on Inpatient Chart or ePMA entry	Comment s
DATE OF CHECK:	PT INITIALS:	BED NO:	ATO INITIALS:	TECHNICIAN/ PHARMACIST INITIALS:	
Medication name/strength form:					
Nature of Discrepancy (tick below appropriate heading)-	Green Sticker Missing	<14 Days Supply Remaining	Missing from Locker	In Locker but not on Inpatient Chart or ePMA entry	Comment s
DATE OF CHECK:	PT INITIALS:	BED NO:	ATO INITIALS:	TECHNICIAN/ PHARMACIST INITIALS:	
Medication name/strength form:					

Nature of Discrepancy (tick below appropriate heading)-	Green Sticker Missing	<14 Days Supply Remaining	Missing from Locker	In Locker but not on Inpatient Chart or ePMA entry	Comments