

USE OF PATIENTS OWN DRUGS (PODs) FOR IN-PATIENTS IN HOSPITAL	
Standard Operating Procedure (SOP)	
Ref No: 1836 Version: 4	
Prepared by: Governance Pharmacist & Medication Safety Officer	
Presented to: Care and Clinical Policies Group Medicines Management Committee	Date: 20 June 2018 19 July 2018
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	Review date: 27 July 2021
Relating to policies:	G0806 Medicines Policy

1. Purpose of this Document

The purpose of this document is to provide a framework for handling and assessing inpatients own medications, for healthcare staff employed by Torbay & South Devon NHS Foundation Trust (TSDFT).

2. Scope

This document applies to all registered professionals involved in administration of medicines. All practitioners must be deemed competent in assessing patients own medication (PODs) on admission to a hospital setting.

3. Introduction

There are circumstances when individuals are admitted to hospital and they or their relatives or carer bring in their own medication. In this environment it may be appropriate for patients to continue to use their own medication in the short term. PODs should only be used whilst awaiting a supply from pharmacy. Occasionally it may be necessary to use PODs for a longer period of time.

Staff administering patients own drugs, or supporting patients to take their own medication, must work according to organisational policies, guidelines and professional codes of practice.

Patient's own medication remains the property of the patient and must not be destroyed or disposed of without their consent.

4. Assessment of Patient's Own Medicines

- 4.1 Where it is appropriate to use PODs patients must have their medication assessed and documented as being available and suitable to use.
- 4.2 PODs must be stored in accordance with the Trust's policies and associated SOPs / documentation.
- 4.3 Verbal consent for the use of patients own drugs must be obtained from the patient, relative or carer (as appropriate).
- 4.4 On receipt of the medication the registered practitioner must check: (using Appendix A as a guide)
- The medication packaging is intact, in good condition and within the expiry date.
 - The medication matches the packaging and label.
 - The medication is clearly labelled and displays the following information:
 - Patient's name.
 - The name, strength and formulation of the medication.
 - Dose and instructions, which must be clear, relevant and current.
 - Applicable warnings.
 - The name and address of supplier.
 - Date of dispensing.
 - Expiry date of the medication. (Where not available the medication must have been dispensed within the last 6 months for loose dispensed tablets or 28 days for controlled drugs).
- 4.5 Blister packs are **not** to be used except under exceptional circumstances where a missed dose may cause harm to the patient, the patient is self-medicating or as part of a rehabilitation package. When assessing a patient's blister pack it must meet the criteria identified in 5.4 above and the **expiry date is 4 weeks from the date of dispensing**.
- N.B.** This does not include unlabelled dosette boxes and blister packs filled by the patient, relative or carer. These must **not** be used.
- 4.6 All medicines assessed as suitable for use must be stored in the appropriate locked storage area (POD locker, medicine trolley or treatment room drug cupboard) and POD endorsed in the appropriate section of the Patient Medication Administration Record (PMAR) chart. Please ensure the POD locker does not contain another patient's medication or any other items before placing the patient's medication into it.

- 4.7 Items such as inhalers, eye drops, creams and Glyceryltrinitrate (GTN) spray / tablets can be kept in the patient bedside locker for self-administration. Ensure that this is documented in the relevant section of the PMAR chart or in the patient's notes.
- 4.8 Items which require refrigeration and controlled drugs must be documented and stored appropriately.
- 4.9 POD's must not be used if, following assessment, they are not deemed suitable by the registered practitioner.
- 4.10 Medicines found to be unsuitable for use or no longer required should be returned to the patient and advice given to return them back to their community pharmacy for safe disposal. If this is not possible, obtain consent from the patient to return the PODs to pharmacy for destruction.
- 4.11 An over the counter product may be administered if it is prescribed on the appropriate documentation and the packaging is intact, in good condition and the product is in date.
- 4.12 When a change is made to the patient's prescription the medication must be re-dispensed and labelled by pharmacy, as soon as possible. Medication including blister packs must be discarded utilising the correct procedure, as in 5.10.

Staff are not permitted to alter any instructions on a dispensed label.

5. Administration by Staff using Patients Own Drugs

- 5.1 When administering medicines from the patient's own supply the registered practitioner must follow the principles for the administration of medicines outlined in the medicines policy. All registrants must operate within their professional code and competency and adhere to organisational policies.
- 5.2 Medicines in the locked cabinet or bedside locker must be checked that they are correct (name of patient and medication), and identified against the PMAR and/or the authorisation sheet.
- 5.3 If a medication cannot be supplied immediately, medicines belonging to another patient must **not** be used. The on-call pharmacist should be contacted.
- 5.4 Any medicines not given to the patient or omitted doses must be documented on the prescription chart.

6. Self-administration using Own Drugs

For patients wishing to self-medicate refer to your ward pharmacist. Patients will need to be assessed and to sign an agreement.

7. Returning Patient's Own Medication on Discharge

Patient's own medication should ideally be returned to pharmacy to be included into the take home medicines (TTA). Where the POD remains on the ward then on discharge, the registrant will ensure that:

- The medication is current with correct labelling.
- The medication is labelled for the patient.
- The patient has the correct medication, prescription and/or discharge summary.
- The medication has been checked by a registered staff nurse, or by a registrant if out of hours.
- The patient has sufficient medication issued to cover them until they can obtain further supplies. If they do then the TTA should be endorsed with 'POD' in the pharmacy box to prevent a further supply being issued.
- The patient is aware of any new medicines and/or changes of dose, brand or route to their regular medication.
- All PODs contain patient information leaflets (see <https://www.medicines.org.uk/emc/>).
- All the medication is returned to the patient on discharge/transfer or consent is obtained for the disposal of the medication.
- Advice is given to the patient, if they do not give consent for the disposal, on accumulating excess medication and the need to safely dispose of medication to avoid the potential risk of possible under dose/overdose or inappropriate treatment.

N.B. Medication bought in by the patient **cannot** be taken into hospital stock as the quality cannot be guaranteed and it is important to be aware that these medicines are the property of the patient and must not be used in the treatment of another patient.

8. Incidents

- 8.1 All incidents relating to PODs must be reported on the Trust incident reporting system in accordance with the organisational Incident Reporting Policy.
- 8.2 The prescriber must be informed of any incident relating to the use of the PODs.

9. References

NICE Guidance: Medicines adherence reviewed November 2016

<https://www.nice.org.uk/guidance/cg76> accessed 21.06.18

Nursing and Midwifery Council; Standards for Medicines Management Aug 2007

reprinted August 2010 <https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/> accessed 21.06.18

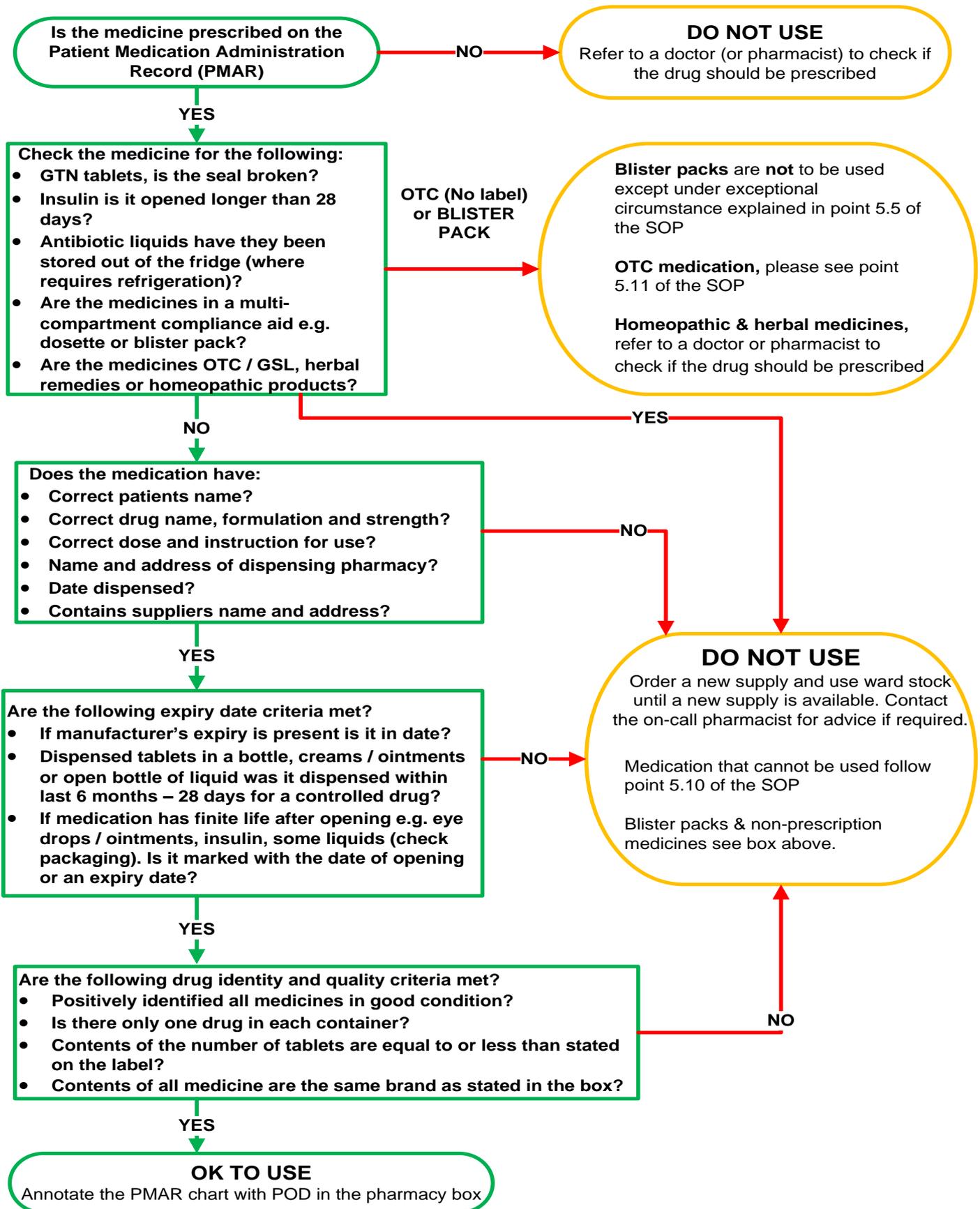
Nursing and Midwifery Council. The Code. Standards of Conduct, Performance and Ethics for Nurses and Midwives 2015 <https://www.nmc.org.uk/standards/code/> accessed 21.06.18

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1		October 2012	Adoption of NHS Devon SOP	Pharmacist
1.1		October 2013	Updated following consultation with matrons	Pharmacist
2		October 2013	Ratified by Care & Clinical Policies	Pharmacist
2.1	Draft	October 2015	Two year review and update	Pharmacist
2		December 2015	Ratified by Care & Clinical Policies	Pharmacist
3	Ratified	20 October 2017	Review date extended	Care and Clinical Policies Group
3	Ratified	9 March 2018	Review date extended	Care and Clinical Policies Group
4	Ratified	27 July 2018	Revised	Care and Clinical Policies Group Medicines Management Committee

[Appendix A – Flow diagram for the Assessment and use of Patient’s Own Drugs \(PODs\)](#)

Flow diagram for the Assessment and use of Patients' Own Drugs (PODs)



The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Policy Title (and number)		Version and Date	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users <input type="checkbox"/>		Staff <input type="checkbox"/>	Other, please state... <input type="checkbox"/>
Could the policy treat people from protected groups less favorably than the general population?			
<i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual Orientation			Yes <input type="checkbox"/> No <input type="checkbox"/>
Religion/Belief (non)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Marriage/ Civil Partnership			Yes <input type="checkbox"/> No <input type="checkbox"/>
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language ⁵ used throughout?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible ⁶ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centred care?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			

Who was consulted when drafting this policy?			
Patients/ Service Users <input type="checkbox"/>	Trade Unions <input type="checkbox"/>	Protected Groups (including Trust Equality Groups) <input type="checkbox"/>	
Staff <input type="checkbox"/>	General Public <input type="checkbox"/>	Other, please state... <input type="checkbox"/>	
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	
AUTHORISATION:			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form		Signature	
Validated by (line manager)		Signature	

Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [GDPR](#) page on ICON.