

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Use of Patients' Own Drugs (PODs)

Effective: October 2009

Review: October 2010

1. Policy Aim

This Policy outlines how patients' own drugs (PODs) are to be:

- received into the Trust
- assessed / identified as being suitable for use
- disposed of if unsuitable
- transferred between wards
- returned to the patient at discharge

2. Policy Scope

This Policy is intended for nursing staff and should be read in conjunction with the [Patient Self Administration of Drugs in Hospital Policy](#) and the [Medicine Policy](#). The assessment of PODs will only be undertaken by nursing staff on identified wards where medication changes during admission are infrequent (and therefore pharmacy input is not required).

3. Introduction

This Policy, in line with Audit Commission recommendations, supports the optimum, safe use of PODs and an overall reduction in medicines expenditure and waste.

Benefits to nursing staff include a reduction in the amount of medicines to be ordered, fewer missed doses, and faster discharge (and therefore fewer complaints from patients). Assessment of POD may also be the first step in setting up a patient self administration scheme.

The Pharmacy Department must be consulted / provide the required training before a POD assessment can take place on a ward.

4. Definition

Throughout the Policy "labelled medicines" refer to medicines that are labelled by a pharmacy with details of the patient name, drug name and strength, directions for use, date dispensed and name and address of supplying pharmacy.

5. Policy

5.1 Receiving PODs into the Trust

Green POD bags are to be carried by all North East Ambulance Service ambulances for use during non-elective hospital admissions. They are to be distributed at pre-assessment / Outpatient clinics to all elective patients. The patient's medication will therefore normally be brought into hospital in these

green POD bags (NB this does not negate the need for careful checking on receipt onto the ward).

Responsibilities of Admitting Nurse:

- It is the responsibility of the admitting nurse to add the patient's addressograph label to the green POD bag as soon as possible in order to minimise the risk of the drugs being mixed-up or lost.
- If the patient does not have a green POD bag they should be given one with their addressograph label stuck on. Any medication they have with them (except controlled drugs) must then be placed in that bag. Patients' own controlled drugs must be stored in the controlled drugs cupboard as per Medicine Policy.
- The patient must be informed that their green POD bag and medicines (except controlled drugs) will be stored in their locked bedside medication locker.

Pre- Assessment Clinic Staff

- A green POD bag, with an addressograph label attached, must be issued to all patients when they attend clinic. This will need to be rechecked on admission in case there are any changes in details e.g. change of address/GP
- Patients will be instructed to bring a sufficient supply of their medication (in the labelled original container) into hospital with them in the green POD bag. They must also bring items that the medical staff have asked them to stop prior to the procedure e.g. warfarin.

5.2 Assessing PODs for suitability for use.

On identified wards where medication changes during admission are infrequent (and therefore pharmacy input is not required) PODs will be assessed by nursing staff.

5.2.1 PODs can only be used if they meet the following criteria:

- The patient is correctly prescribed the medicine on the inpatient drug chart (if not confirm the medicine has been intentionally discontinued and if an accidental omission is identified ensure the medicine is prescribed).
- It can be confirmed that the medicine has been stored appropriately prior to admission (e.g. refrigerated medicines have been stored in the refrigerator).
- The medication (and label if present) appears clean and of an acceptable standard for use.
- For unlabelled items the medicine is in its original manufacturer's packaging (e.g. foil strips, inhalers) such that the identity of the medicine and its expiry date can be determined.
- For labelled boxes containing a medicine in its original manufacturer's packaging that the drug name, form and strength on the label match the medicine contained in the box.

- It can be determined from the packaging (or label if required) that the expiry falls within the criteria outlined in appendix 1.

5.2.2 Other considerations:

- PODs that do not have an appropriate label attached will, under normal circumstances, need to be labelled prior to discharge and therefore pharmacy (as per local agreement) should be contacted at the earliest opportunity (during normal working hours) to facilitate this.
- Patient's own controlled drugs can be utilised as per other drugs during inpatient stay / discharge but records of receipt / issues must be recorded in the "Patients' Own Controlled Drug Book" as outlined in the Medicine Policy, and they must be stored in the ward controlled drug cupboard.
- Multiple medications stored in the same container for example a Medibox must not be used.

5.2.3 Identification / storage of PODs deemed suitable for use

- To prevent potential duplication of work a "POD checked as suitable for use" sticker should be attached to each POD assessed as suitable for use. The date of assessment and initials of the nurse undertaking the assessment should be written on the sticker.
- PODs deemed suitable for use must be stored in the individual bedside medication locker. Exceptions include controlled drugs, medicines requiring cold storage and medicines that may be urgently required by the patient e.g. GTN spray, reliever inhaler.

5.3 Disposal in PODs deemed unsuitable for use.

- PODs deemed unsuitable for use (including controlled drugs) should be disposed of in accordance with the Medicines Policy.

5.4 Transfer of PODs between wards.

- PODs are the patients' property and therefore they **must** be transferred (in the green POD bag) with the patient and the patient's personal belongings if the patient is transferred to another ward.
- If the patient does not have a green POD bag then one must be supplied with the patient's addressograph label attached.
- If a signed / dated "POD checked as suitable for use" sticker has been attached to a POD a second check will not need to be performed by staff on the receiving ward.

5.5 Use of PODs on discharge

- On identified wards where medication changes during admission are infrequent (and therefore pharmacy input is not required) nursing staff

will check PODs are suitable for issue at discharge (i.e. directions on the label match the prescribed dose) in accordance with the “Checking Procedure For Discharge Prescriptions” in the Medicine Policy.

5.6 Key Custody – Individual bedside lockers

- This section should be read in conjunction with the “Custody and Storage” section of the [Medicine Policy](#).
- Each ward will have 2-3 (depending on how many staff are likely to administer medicines at the same time) **clearly labelled** master keys for their individual patient bedside medication lockers.
- The responsibility for the safe custody of these master keys lies with the nurse in charge of the ward but all staff must be made aware of the security risk posed if a master key is lost or stolen.
- At the end of each shift master keys must be formally handed over to the appropriate nursing coming on duty.
- On any occasion when a master key is lost or stolen it must be reported through the Trust’s incident reporting system and a prompt and thorough investigation initiated involving pharmacy and the manager of the area (as outlined in the [Medicine Policy](#)).
- If required / appropriate a spare key may be accessed via Patient Services Co-ordinators who hold spare keys in an appropriate location under approved safeguards.

6. Audit and Monitoring / Review

Compliance with the Policy will be audited every 12 months by an Assistant Director of Pharmacy. The audit will monitor patients’ own drug assessments, transfer and re-use at the point of discharge on 6 wards (3 RVI and 3 Freeman) over a 1 week period.

This Policy will be reviewed every 2 years. Comments on the content or implementation of this policy should be directed to Director of Nursing and Patient Services and the Director of Pharmacy.

Policy author: Assistant Director of Pharmacy

Appendix 1

Expiry Date Criteria

Tablets	Manufacturer's expiry (or if unknown, dispensed in the last 6 months)
Inhalers	Manufacturer's expiry
Suppositories/pessaries	Manufacturer's expiry
Creams	1 month after opening (or if unopened manufacturer's expiry)
Eye and ear drops	2 weeks after opening (or if unopened manufacturer's expiry)
Liquids/syrups	1 month from the date of dispensing (or stated expiry date)
Insulin	1 month after opening (or if unopened manufacturer's expiry)

Specific medicines

GTN spray	Manufacturer's expiry date
GTN tablets	6 weeks after opening (or if unopened manufacturer's expiry)
Persantin Retard	6 weeks after opening (or if unopened manufacturer's expiry)
Nicorandil	Not to be used if the foil strip has been cut.

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Use of Patients' Own Drugs	Policy Author:	Steven Brice
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	Affects all patients prescribed medicines prior to admission
	• Ethnic origins (including gypsies and travellers)	No	Affects all patients prescribed medicines prior to admission
	• Nationality	No	Affects all patients prescribed medicines prior to admission
	• Gender	No	Affects all patients prescribed medicines prior to admission
	• Culture	No	Affects all patients prescribed medicines prior to admission
	• Religion or belief	No	Affects all patients prescribed medicines prior to admission
	• Sexual orientation including lesbian, gay and bisexual people	No	Affects all patients prescribed medicines prior to admission
	• Age	No	Affects all patients prescribed medicines prior to admission
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	Affects all patients prescribed medicines prior to admission
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	n/a	
4(a).	Is the impact of the policy/guidance likely to be negative? (If "yes", please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?	n/a	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	n/a	
4(d).	Can we reduce the impact by taking different action?	n/a	

Comments: Aim to maximise the reuse of patients' own drugs thus reducing waste	Action Plan due (or Not Applicable):

Name and Designation of Person responsible for completion of this form: Steven Brice, Assistant Director of Pharmacy

Date: 21st October 2009

Names & Designations of those involved in the impact assessment screening process:.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)