USE/DESTRUCTION OF PATIENT’S OWN MEDICINES

1. INTRODUCTION

1.1. It is permissible to use a patient’s own medicines brought with them on admission to an inpatient unit, provided these have been assessed as suitable for continued use. This document includes an algorithm (see Annex 1) which should be used by registered practitioners, nursing or pharmacy staff to assess whether a patient’s own medicines are suitable for use.

1.2. This algorithm can be used for assessing a patient’s own controlled drugs, but additional record-keeping requirements apply. Refer to Appendix 3 of CLPG13.

1.3. If a patient’s own medicines have been assessed as suitable for continued use, consent to do so must be obtained. This may be verbal consent, recorded in the patient’s healthcare record, or obtained using the form contained in Annex 2.

1.4. If a patient’s own medicines are not required because the admitting doctor decides to discontinue the treatment, or they are assessed as unfit for use, consent should be sought for the medicines to be disposed of as pharmaceutical waste on the in-patient unit. This may be verbal consent, recorded in the patient’s healthcare record or obtained using the form contained in Annex 3.

1.5. If permission to destroy a patient’s own medicines is not granted, they should be sent home in the same way as any other property not required by the patient. Patients and carers should receive adequate warning that the medicines are no longer intended to be taken or are unfit for use.

1.6. If the patient is unable to give consent staff should refer to the principles of the Mental Capacity Act 2005 (see the Trust Mental Capacity Act 2005 Policy (MCP2) and Mental Capacity Act 2005 Procedure (MCPG2); see also section 9.4 of CLPG13).

1.7. In some circumstances, a member of a community team may be asked or may feel it necessary to remove unwanted/excess patients’ own medicines for destruction when reviewing a patient at their place of residence; at the end of treatment or following death of the patient. If medicines are removed and transported to a community pharmacy for destruction, written consent should be sought or witness signature if possible, using the Form “Consent To The Removal Of Medicines Including Controlled Drugs From Patients’ Homes For Safe Disposal (Community)” in and this should also be filed in the patient’s healthcare record. (Annex 4) This form should be used to record the removal for destruction even if consent is not possible to obtain - where there is no second person available to witness or give permission, annotate the
record with “no second person available” or “no person available to give permission”.

SAMPLE - DO NOT USE
ALGORITHM FOR ASSESSING WHETHER A PATIENT’S OWN MEDICINE IS SUITABLE FOR CONTINUED USE WHILST AN INPATIENT

1. Name on label matches patient’s name?  
   - **YES**  
     - **YES**  
       - Drug prescribed by GP?  
         - **YES**  
           - Drug in original dispensed container?  
             - **YES**  
               - Container, label and drug in good condition?  
                 - **YES**  
                   - Drug dispensed within last 12 months?  
                     - **YES**  
                       - Pack within manufacturer’s expiry date or within expiry date stated on pharmacy label?  
                         - **YES**  
                           - Drug name, form and strength on label agree with contents of pack?  
                             - **YES**  
                               - Drug is tablets/capsules in blister pack(s)?  
                                 - **YES**  
                                   - Are there any special storage requirements, e.g. refrigeration?  
                                     - **NO**  
                                       - DO NOT USE
                                     - **UNOPENED**  
                                       - DRUG IS SUITABLE TO USE
                                 - **NO** (i.e. loose tablets/capsules)  
                                   - Refer to Pharmacy
                             - **NO** / **NO DATE**  
                               - DRUG IS SUITABLE TO USE
                           - **NO** / **UNCERTAIN**  
                             - DRUG IS SUITABLE TO USE
                         - **NO** / **UNDATE**  
                           - DRUG IS SUITABLE TO USE
                       - **NO**  
                         - DO NOT USE
                     - **NO**  
                       - Refer to Pharmacy
                 - **NO**  
                   - DO NOT USE
               - **NO**  
                 - Refer to Pharmacy
             - **NO**  
               - Refer to Pharmacy
           - **NO**  
             - DO NOT USE
         - **NO**  
           - Refer to Pharmacy
   - **NO**  
     - **DO NOT USE

2. Drug is another formulation?  
   - **YES**  
     - Refer to Pharmacy
   - **NO**  
     - DRUG IS SUITABLE TO USE
PATIENT CONSENT TO USE THEIR OWN MEDICINES (INPATIENT UNITS)

<table>
<thead>
<tr>
<th>Patient’s name:</th>
<th>NHS Number:</th>
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<tbody>
<tr>
<td>Ward:</td>
<td>Date of Admission:</td>
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</table>

1. I agree to the continued use of my own medicines (listed below), whilst I am an inpatient.

2. I understand that any remaining supply of my medicines will be returned to me on my discharge. If my own supply of any of these medicines runs out whilst I am an inpatient, I understand that an additional supply will be provided for me.

3. Any of my medicines that are discontinued by a doctor whilst I am an inpatient may be disposed of.

4. I understand that my medicines will be stored in a locked cupboard, and given to me by a member of the nursing staff at the appropriate times.

<table>
<thead>
<tr>
<th>Drug name and formulation</th>
<th>Strength</th>
<th>Directions</th>
<th>Quantity</th>
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Signature: ___________________________  Date: __________

This form should be filed in the patient’s healthcare record.

SAMPLE - DO NOT USE

SAMPLE - DO NOT USE
PATIENT CONSENT TO THE SAFE DISPOSAL OF UNWANTED MEDICINES INCLUDING CONTROLLED DRUGS (INPATIENTS)

Dear Patient

Thank you for bringing your medicines in with you when you were admitted.

The following medicine(s) are no longer required for your treatment, or are not suitable for use. We would like to ask your permission to dispose of them safely on the ward, in line with environmental guidelines and regulations. If you consent to these medicines being disposed of, please sign the box below.

Thank you

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>NHS No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward/unit</td>
<td>Date</td>
</tr>
<tr>
<td>Qualified nurse</td>
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</tbody>
</table>

**Medicines to be disposed of:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Form</th>
<th>Quantity</th>
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Patient signature for consent to destruction

If you do not consent to these medicines being destroyed on the ward, they will be stored safely until you are ready to be discharged. You will then have the opportunity to consent to their destruction on the ward, or to take them home with you. If you decide to take them home, even though you no longer require them for your treatment, you are advised to take them to a community pharmacy for safe disposal.

**Nursing staff:** If the medicines listed above include a Controlled Drug, and the patient consents to disposal, this form should be placed inside the CD Record Book pending denaturing of the item by an approved person.
CONSENT TO THE REMOVAL OF MEDICINES INCLUDING CONTROLLED DRUGS FROM PATIENTS’ HOMES FOR SAFE DISPOSAL (COMMUNITY)

Dear Patient/ Carer,

We would like to ask your permission to DISPOSE of the following excess/unwanted medicines, in line with guidelines and regulations by taking them for destruction to a community pharmacy. If you consent to these medicines being disposed of on your behalf, please sign the box below.

Thank you

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<tr>
<th>Name of Patient:</th>
<th>DOB</th>
<th>NHS No:</th>
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<tbody>
<tr>
<td>Team:</td>
<td>Date of removal</td>
<td>Time of removal</td>
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<td>Reason for Removal:</td>
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<td>Name of Registered Healthcare Professional Removing medication:</td>
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<td>Signature:</td>
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<th>Medicines to be disposed of:</th>
<th>Strength</th>
<th>Form</th>
<th>Quantity</th>
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<tr>
<td>Controlled Drugs to be disposed of:</td>
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<tr>
<td>State Name if not the patient:</td>
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Patient /carer /witness/signature for consent: (delete as appropriate)
Nursing staff. Medicines may only be removed for disposal by EPUT staff under exceptional circumstances. (Refer to CLPG13-CHS) Any medicines removed from patient’s homes must have consent, either from the patient, their carer/family if they lack capacity, or in the case of deceased patients, where possible their family or another witness to the removal. This document should be scanned into the patient’s healthcare record.

Pharmacy details:
Please complete details below for the pharmacy to which the medicines have been taken for destruction:

<table>
<thead>
<tr>
<th>Name of Pharmacy:</th>
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<tbody>
<tr>
<td>Address:</td>
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<tr>
<td>Tel no:</td>
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</table>

I confirm that I have received the medicines listed overleaf for destruction:

Signature of Pharmacist:..............................................................................................................................................

Date................................................................................................................................................................................

Name of Pharmacist...............................................................................................................................................................

Signature of Registered Nurse/Healthcare Assistant........................................................................................................

Date: ....................................................................................................................................................................................

Name of Registered Nurse/ Health care assistant..............................................................................................................