KATHARINE HOUSE HOSPICE

Patient Self-Administration of Medicines Policy and Procedure.

Approved by:

Date of approval:

Originator: Medical Director

Statutory regulations

Independent Health Care National Minimum Standards Regulations, Hospice Standared H9.7
Misuse of Drugs Act Regulation 1973

Relevant external guidance

NMC Standards for the Administration of Medicines 1992

Related Policies

Drug Policy

Responsibilities

Medical Director	To maintain a policy and procedure for the self-administration of medicines by suitable hospice inpatients.
Clinical staff	To apply and follow the Patient Self-Administration of Medicines Policy and Procedure as clinically appropriate.

Introduction

Most patients in the community have to take charge of their own medication. There is no reason why some of them should not take care of their own medicines whilst in the hospice, particularly if they are on stable regimens. Indeed, such an approach may hold advantages for patients, such as gaining:

- A better understanding of the formulation and packaging of each medicine, along with the clinical indications for use, the times they should be taken and any special instructions regarding them.
- An opportunity to try out a "medication box" should they wish.
- Greater autonomy and self-confidence regarding the management of their medicines, in preparation for returning home.

It has even been suggested that self-medication whilst an inpatient can improve drug compliance after discharge. However, self-administration of medicines requires

appropriate education, supervision and monitoring by hospice staff if it is to be successful.

In accepting admission to a hospice, it is implicit that patients are prepared to release a degree of autonomy in return for receiving specialist care in a safe environment. However, they will wish to retain as much autonomy as is practicable and the hospice must respect this. At all times, the patient's right to autonomy must be balanced against the hospice's duty of care and its responsibility for ensuring the safety of all its service users. Patient self-administration of medication must not put these duties and responsibilities at risk.

Who is eligible for self-medication?

It would be unfair to offer self-administration of medicines to patients who are clearly unsuitable for this. Therefore it is important to consider the medication regimen and the patient in each instance.

Medication Regimen

Self-medication makes most sense for patients whose medication regimen is not subject to regular revision and when the patient is used to taking charge of their own medication. This is likely to be the case when symptoms are under good control, such as during a respite admission or towards the end of a successful admission for symptom management.

Patient factors

For self-administration of medicines to work, it is necessary for the patient:

1. **To be motivated to take on this role.**
   Some patients may express no interest in self-medicating. In some cases, this could be because they are suffering from severe anxiety or depression whereas in others it could be due to severe general debility or a wish to rely on others for this activity.
2. **To have the cognitive ability to self-medicate.**
   Patients need to understand what medicines they are taking, the indications for these medications, the times at which they are taken and any important potential side effects or other information of note. They also need to be able to act autonomously.
3. **To have the visual skills to recognise the various medicines.**
   To be safe at self-administration of medicines, patients need to be able to see what they are doing. They also need to be able to read any necessary information sheets and the labelling on any drug packaging.
4. **To have the manual dexterity to self-medicate.**
   The actual act of self-administration requires a degree of strength and manual dexterity. Patients will need to be able to open the locked bedside cabinet to access the medication and then perform the appropriate functions that may include:
   - Opening bottles and counting out tablets
   - Opening blister packs and counting out capsules
   - Pouring out precise volumes of liquid
   - Administering eye drops
   - Using inhalers
   - Applying creams or ointments

- Inserting suppositories or pessaries
- Injecting themselves
- Using a PEG tube

Contraindicated medications

It is possible that some parts of a medication regimen are suitable for self-administration whereas others are not. For example, ***under no circumstances would we allow an inpatient the opportunity to take full control of their Controlled Drugs or drugs that require refrigeration, nor would we expect them to draw up and site their own syringe drivers***. The hospice's "Risk assessment for including Controlled Drugs in the Self-Medication regimens of hospice inpatients" is available from either Clinical Director.

The need for a flexible approach

Depending on an individual patient's confidence and dexterity, certain procedures may or may not be suitable for self-administration, such as the administration of eye drops. Over time, confidence and competence may improve, thereby allowing more tasks to be willingly taken on by the patient. Alternatively, it may become apparent that certain activities are too difficult for the patient to undertake reliably, necessitating the nursing staff to take over these activities once more. Bearing all of these considerations in mind, all self-administration procedures must be individualised for the patient and subject to regular review.

Procedure

1. The named nurse and a member of the medical team agree whether or not it is suitable to assess a patient for potential self-administration of their medicines. If so, then the patient is formally assessed by a nurse using the Self-Medication Checklist (Appendix One). The final outcome of this nursing assessment is documented in the medical and nursing notes.

2. If the patient passes the assessment process, then they are approached by the named nurse and offered the opportunity to consider self-medication. If provisional interest is shown, then the patient is given the information sheet on self-medication (Appendix Two) for them and their family/friends to consider.

3. If interest is confirmed, then the patient and nurse agree which drugs are for self-medicating and the appropriate level of self-medication to adopt. An informed consent sheet is signed (Appendix Three) and this is stored in the back of the medical notes where old drug charts are placed. The self-medication status is recorded on the patient's care plan and the whole nursing team is informed of the self-medication status at subsequent handovers.

Level 1
- The patient's medications are stored in a locked bedside cabinet but the patient does not have a key.
- The nurse dispenses all the medication from the locked bedside cabinet on each drug round, giving the patient full and appropriate explanations regarding each drug, including its clinical indication.

Level 2
- The patient's medications are stored in a locked bedside cabinet but the patient does not have a key.
- The patient asks for medication at the appropriate times and the cabinet is unlocked.
- The patient administers their own medication from the bedside cabinet with nurse supervision. The patient explains what each medicine is for.
- The nurse only intervenes if the patient is about to make a mistake.

Level 3
- The patient's medications are stored in a locked bedside cabinet and the patient has a key.
- Unsupervised self-administration.
- The nurse enquires once a day whether self-administration is going OK.
- Random checks of stocks in the locked cabinet are allowable.

4. The patient is given a personalized Medication Summary Sheet. This contains information on each prescribed drug, a description of the formulation, the dose, timing, reason for use, any notable side effects and any other important comments. The information on this sheet is carefully explained to the patient.

5. The patient's medication still needs to be prescribed on an up-to-date drug chart and this will need to be rewritten if the current chart expires. A sticker is placed on the front page of the drug chart to indicate that the patient is self-medicating, including the level of self-medication and the date at which it started. The initials "SM" are written in red ink in the comments box of each drug that the patient self-medicates.

6. A self-administration of medicines checklist is placed inside the drug chart for the nurses to complete appropriately.

7. The Patient's Own Drugs (excluding controlled drugs, medications requiring refrigeration and any other agreed medicines) are placed in the locked bedside cabinet for medicines and the appropriate protocol is followed.

8. If the Patients Own Drugs are imminently going to run out, then a further seven-day supply of the relevant items is ordered from Pharmacy in a timely manner. This is done on a named-patient basis using the TTO prescription book.

9. **If dosage instructions for any drug change during the course of the admission, then self-administration of that particular drug must be suspended until such time as the container for those drugs has been relabelled with the correct instructions and the personalized Medication Summary Sheet has been rewritten**. Whilst self-medication of a particular drug is temporarily suspended, the drug in question must be administered by nurses from the drug trolley.

10. If any new drug is introduced to the medication regimen during the admission, then self-administration of that particular drug can only start when the patient has been issued with their own correctly-labelled supply and the personalized

Medication Summary Sheet has been rewritten. Until that time, the drug in question must be administered by nurses from the drug trolley.

11. On discharge from the hospice, the patient must have a seven-day supply of correctly labelled drugs to take home with them. This can be made up of Patient's Own Drugs that they brought in with them and top-ups to the PODs that are ordered from Pharmacy on a named-patient basis using the TTO prescription book.

12. At the end of any admission, the hospice will recommend that any unwanted drugs are retained by the hospice and destroyed. When the admission has ended in the death of a patient, no drugs must be destroyed for at least seven days in case they are required by the Coroner. As these drugs are the property of the patient and not the hospice, the patient and/or family presumably retain the right to demand their return even if they are not clinically needed by the patient any more.

Potential Problems

Self-medication is fraught with potential problems and the following list is far from exhaustive. Any problems that arise need to be dealt with in a prompt and appropriate manner that is individualised to the patient. Inform a doctor promptly of any problems. The following approaches should generally be adopted to the given situations.

Problem	**Course of action**
Changes to the regular prescription.	Frequent changes to the routine medication are an indication for suspending self-medication.
Some medications still require administration by staff rather than the patient.	These should be agreed from the outset. Appropriate revisions can be made over time.
Disposal of sharps	Small sharps bin with a lid to be placed in the locked cupboard.
Monitoring PRN drug use.	PRN use will need to be documented by the patient on a special sheet so that the clinical team can monitor the level of symptom management better.
Drugs with specific storage requirements (e.g. flammable materials, drugs requiring refrigeration)	These will be kept in a safe place by the nursing team and given to the patient on request.
Gross failure to self-medicate.	Find out why. This could be an indication to suspend self-medication.
Drugs that are unaccounted for.	Find out why. This could be an indication to suspend self-medication.
Failure to store drugs in the locked cupboard.	Find out why. This could be an indication to suspend self-medication.
Overdose, accidental or deliberate.	Immediately inform a doctor. Dealing with the medical emergency takes priority over other considerations in the first instance.
Lost keys	The key will be issued on a necklace. The senior ward nurse will have a spare.

Appendices

1. Self-Medication Checklist.
2. Patient Information Sheet for Self-Medication.
3. Patient Consent Form for Self-Administration of Medicines.

Self-Medication Checklist

(To be completed by the named nurse and stored with the corresponding drug chart at all times)

Patient Name

In order to be a suitable candidate for self-medication, the answer to each of the following questions must be "Yes".

	Yes	No
Stable drug regimen		
Motivated patient		
Necessary cognitive skills		
Necessary visual skills		
Necessary manual dexterity		

Who will administer each of the following types of medication?

	Self-administration	Nurse-administration	Not applicable
Oral tablets and capsules			
Liquid medications			
Eye drops			
Inhalers			
Creams/ointments			
Suppositories/ Pessaries			
Regular injections			
PEG tube feeding			

NB: Controlled drugs, PRN injections and syringe drivers will always be administered by the nursing team.

Special Considerations

Agreed level of Self-administration

Name of Nurse who assessed the patient

Signature **Date**

The following jobs need to have been performed prior to initiating the self-administration of medicines:

Consent form signed	Date and signature
Self-administration information sheet supplied to the patient	
Drug information sheet supplied to the patient. Drug chart marked up	
Seven-day supply of relevant drugs supplied to patient	
Key supplied to patient.	

Monitoring the Self-Administration Process

For Level One and Level Two, self-administration, the administration of all medicines is documented on the drug chart in the standard manner.

For Level Three, it is appropriate to

- Ask the patient how self-medication is going once during the course of the day.
- Perform random checks on the drug stock in the locked cabinet once every three or four days.

This activity is to be documented below. A satisfactory outcome simply requires a signature in the box whereas a problem also warrants documentation in the nursing notes and discussion with the medical team.

Date	Verbal Enquiry (Signature)	Stock Check (Signature)

Looking after your own medicines whilst in the hospice

Are your medicines the same day after day? If so, you might want to look after them yourself whilst at Katharine House. However, you do not have to do this if you do not want to.

What are the benefits?
Looking after your own medicines might help you understand:

- What your medicines look like.
- What they are for.
- The times at which they should be taken.
- Any special instructions regarding their use.

This might increase your confidence about your medicines when you are home again.

Will you still be supervised or monitored?
Even if you look after your own medicines, you can still receive all the benefits of hospice care, including:

- As much advice and supervision about your drugs from staff as you want, at any time you want.
- The reassurance that all your drugs are still prescribed and monitored by our doctors.

Is it suitable for everyone?
We consider it inappropriate for the following patients to look after their own medicines:

- Patients who are still having their medicines changed in order to control their symptoms.
- Patients who, for various reasons, find their medicines too confusing or difficult to look after themselves.
- Patients who would prefer not to look after their own medicines.

We also do not consider it appropriate for the following types of drugs to be looked after by their patients:

- Highly regulated drugs like morphine.
- Drugs that need to be carefully mixed together in a syringe.
- Drugs that need to be stored in a refrigerator.

(P.T.O.)

Safety

- The hospice is responsible for making sure that its patients remain safe whilst with us. Therefore, not all patients are invited to look after their own medicines.
- Whenever a patient looks after their own medicines, we will still need to monitor them.
- If looking after your own medicines proves too difficult or raises any concerns, then the nursing team will happily take over again.

Doing it in stages

You may wish to take control of your own medicines in stages. For example, you might want to leave everything to the nurses at the start of your stay and then gradually take control again as it gets nearer to going home. There are three levels to choose from and move between:

Level 1

- Your medicines are stored in a locked bedside cabinet but the nurses look after the key.
- A nurse dispenses all the medicines from the cabinet on each drug round, giving you full and appropriate explanations about each drug and the reason for its use.

Level 2

- Your medicines are stored in a locked bedside cabinet but the nurses look after the key.
- You ask for medicines at the appropriate times and the cabinet is unlocked for you.
- You administer your own medicines from the bedside cabinet with nurse supervision. You explain to the nurse what each medicine is for.
- The nurse only intervenes if you are about to make a mistake with your medicines.

Level 3

- Your medicines are stored in a locked bedside cabinet and you have the key.
- You administer your own medicines without any supervision.
- The nurse enquires once a day whether self-administration is going OK.
- To ensure safety, random checks of the remaining medicines in your locked cabinet will be made from time to time.

If you would like to go ahead with this, please talk to your named nurse about which level you would like to start on.

Patient Consent Form for Self-Administration of Medicines

I would like to take some responsibility for my own medicines whilst an inpatient.

I have received the patient information on this and had every opportunity to discuss it with my named nurse.

I have agreed to start at level _____ .

I appreciate that:

1. Some parts of my drug treatment might be considered unsuitable for me took take full responsibility for myself, such as the use of "Controlled Drugs", drugs that require refrigeration and medication administered by syringe driver. These have been discussed with me.
2. The staff are ultimately responsible for the safety of all patients. They are required to monitor my medicines and how I use them from time to time. If there are any safety concerns, they reserve the right to take over the care of my medicines again.

Signed _____

Printed Name _____

Date _____

Risk assessment of patient self-medication with their own Controlled Drugs

According to feedback obtained from http://www.palliativedrugs.com, the HealthCare Commission has implied that it is not essential for hospices to make self-administration of Controlled Drugs (CDs) an option for their inpatients. They have also said that:

- The security of a patient's CDs can not be left to the patient: the hospice has responsibility for this.
- The organisation has to demonstrate that a risk assessment has been performed.
- The organisation has a policy for the local security of CDs if it was decided that patients should be allowed to store their own in the hospice.
- Patients own CDs can be stored in their bedside lockers.
- Patients own CDs are the patient's own property.
- Patients own CDs are not subject to the same legal requirements as stock CDs.

"Safer Management of Controlled Drugs A guide to good practice in secondary care (England)" is primarily comprises guidance rather than requirements. It employs the style of the Revised Duthie Report (March 2005), where the term:

- "must" is used for those matters governed by legal requirements.
- "should" is used for recommendations that relate to good practice
- "may" is used for recommendations that relate to good practice, but only if they are relevant to local circumstances.

In relation to patient self-administration of Controlled Drugs, "Safer Management of Controlled Drugs A guide to good practice in secondary care (England)" states:

> "It may be appropriate to use a patient's own CDs (i.e. CDs brought into the hospital by the patient on admission) whilst they are in hospital, for example, if the patient is self-administering other medicines".

It is therefore clear from this wording that it is not mandatory for all healthcare organisations to offer the option of self-administration of CDs to their patients.

Being an independent charitable healthcare organisation, Katharine House Hospice can make autonomous choices on its medicines management systems so long as they comply with the necessary legal requirements. It is evident that there is a wide diversity of practice with regard to the self-medication of non-CDs and the self-medication of CDs amongst hospices in the United Kingdom. Even where patients are actually or theoretically allowed to self-administer their regular CDs in certain hospices, they are typically not allowed to self-administer their PRN doses of CDs.

The following arguments have been made in favour of self-administration of CDs:

- The right for patients maintain possession of and use their personal property.
- The right to privacy.
- The right to autonomy.
- The benefits of becoming familiar with one's medication regimen before discharge from the hospice.

Against these arguments it can be observed that:

- Most of our patients have a great deal of personal property. They generally have neither an expectation nor a right to bring it all into the hospice on admission or to use it on hospice premises. It would even be reasonable for them to have an expectation that they would be asked not to use certain items of their personal property in the hospice, and even not to bring these items in with them. It is widely accepted that people do not generally ask for a specialist service from a specialist provider whilst insisting that they actually continue to autonomously provide that same service for themselves. The pharmacological management of symptoms is one important part of the specialist service provided by a hospice, and it must be able to operate in a free and open relationship with the patient in this area if the best results are to be obtained. Such a free and open relationship might be hard to achieve if the patient's sense of personal property rights are so strongly held.
- Privacy is best preserved in private places. By voluntarily entering a public place such as a hospice, ones ability to maintain one's complete privacy is reduced even if the caring team makes every effort to respect that privacy. It is self-evident that a person can only receive help and/or assistance from other people if they allow those people to get sufficiently intimate with them. It is also self-evident that a hospice inpatient unit fails to act with responsibility or accountability and fails in its duty of care if it simply does not engage with its inpatients in order to preserve their privacy.
- In reality, the self-administration of CDs in hospices is far from an autonomous act. Where it takes place, such patients are:
    - Assessed for their suitability. They need the permission of the hospice to self-administer their CDs, and they are denied this option if the hospice considers them inappropriate for self-administration.
    - Typically only given partial self-administration status, being allowed to self-administer their regular CD doses and not their PRN ones.
    - Only given conditional permission to self-medicate. They can have their self-medication status withdrawn from them at the discretion of the hospice if self-administration is deemed too unsafe.
    - Required to comply with a set of self-administration regulations and procedures that are imposed by the hospice.
    - Monitored for their compliance with the dosage regimen, whether they like it or not. They are even potentially subject to spot checks of their remaining stock of CDs.
- Whilst it can be very important and helpful for some patients to become familiar with their medication regimen before they are discharged home, this will be clearly inappropriate for certain other patients. Self-administration of one's medicines is not absolutely essential for this familiarisation process to take place. For example, various models of "supervised" administration by a nurse can fulfil this role. It is potentially very confusing for a patient to try and familiarise themselves with an unstable and changing medication regimen, and one has to individualise the timing and the detail of any medication familiarisation process.

Disadvantages of self-medication of CDs include:

- Storage/Security issues.
  If patients are to self-medicate their CDs, then these will need to be stored in lockable bedside lockers. CDs are already stored in two locked CD cupboards in the treatment room (and they are taken on the inpatient drug trolley during appropriate drug rounds). Our ability to ensure the security of on-site CDs diminishes as the number of separate storage sites goes up. It also decreases when the keys for these storage sites are more widely distributed and when the keys for some of these sites pass into non-staff hands. Even though the CDs in patient's bedside lockers are the property of the patient concerned, the responsibility for their safekeeping whilst in the inpatient unit lies with the hospice. The hospice is also responsible (within reasonable limits) for the health and safety of all people in the hospice, and for this reason too it must maintain responsibility for all patients' own CDs that are known to be stored anywhere on the premises.

- Titration issues/ Problems with unstable disease
  Many of our inpatients have unstable disease and changing symptoms. As a result of this, their medication regimens are liable to change. However, patients can only self-medicate with medication that is correctly labelled, including correct dosage instructions. Therefore, each time a dosage instruction for a particular drug changes, self-administration of that drug has to be suspended until such time as the drug has been relabelled and re-dispensed. During the course of an admission, several prescription changes might be required and this can lead to a confusing and changing patchwork of medications that can and cannot be self-administered by the patient. This opens both the patient and the organisation to unnecessary drug administration errors. Whilst this problem is not exclusive to CDs, it is nonetheless an important issue with regard to CDs.

- Monitoring PRN usage.
  The correct titration of a patient's regular dose of CD depends very much on their use of PRN CD. If patients are self-administering their PRN CDs then there is a real risk that there will not be 100% documentation of this use on their inpatient drug charts. This makes it harder for the regular dose of CD to be properly titrated.

- Relabelling issues each time the dose changes.
  Every time a dose of medicine is changed, the medication in question must be returned to pharmacy for re-labelling and/or for a new formulation of the same drug to be dispensed. As the pharmacy is off-site, this will introduce an inevitable and potentially quite lengthy suspension of self-administration of the drug in question until the re-dispensed drug is given back to the patient. The medication summary sheet of the patient will also need to be regenerated each time such a prescription change takes place, and the patient will need a variable amount of re-education with regard to the prescription change. This places high demands on courier time, hospice staff time and pharmacy time. It can also be confusing for patients and it is potentially very wasteful of medication that is dispensed only to be changed or withdrawn after a short space of time. Furthermore, it introduces a potential incentive not to refine medication regimens as well as they might be, because of the administrative difficulties that this creates.

- Regular counting of stock in the bedside locker.
  The storage of CDs in patients' bedside lockers introduces a larger number of stock checks of CDs, in new and less secure locations. This adds to the demands of an already exacting procedure, whilst potentially exposing CDs more frequently on the inpatient unit whenever such checks are made. Furthermore, any patient who wishes to self-medicate their CDs as an exercise of their autonomy may fundamentally object to these stock checks.

- Complicated regulations and procedures.
  Even though a patient's own CDs always remain the property of the patient, even when they are on hospice premises, it is the hospice that remains responsible for them and their safety whilst on hospice premises. Therefore the hospice would justifiably want and need to introduce regulations and procedures that would need to be followed by both staff and patient if a patient were to safely self-medicate their CDs on the ward. An undue burden of detailed procedures can become confusing and unmanageable for staff, and unacceptable for adults

who wish to maintain their autonomy.

- Complicated audit trail.
  Patients' own CDs for self-administration have to be signed into the hospice's "Patients' Own CD Record Book" and then immediately signed out again and put into a register of "patients' own CDs that are stored at the bedside". This then needs to be regularly stock-checked. Unlike other CDs for inpatient use, fresh supplies of these CDs would confusingly need to be ordered as TTOs and then signed in through the above procedure. Any redundant CDs during or at the end of the admission would need to be signed back into the hospice's "Patient's Own CD Record Book" before being destroyed or simply handed back to the patient for them to do with as they wished on the basis that these CDs are their own property. The latter option could be viewed as a potentially unsafe one in that they release therapeutically unnecessary CDs into the community. They could not be introduced into general ward stock as they had been issued to a named patient. This introduces the potential for a great deal of extra CD waste.

- It does not give the patient autonomy or privacy.
  This has already been covered in some detail.

- Ownership and responsibility issues.
  The difficulties and tensions that can arise from split ownership-responsibility of the CDs in question have already been highlighted above.

- Changing autonomy/dependence levels.
  Not only do hospice patients often have unstable symptoms that require changes to their medication regimens, they can also have changing dependency levels. Patients with the capacity to self-medicate one day may lose this on the next, and their capacity in this area might even repeatedly come and go over time. If the hospice is to demonstrate that it is acting responsibly in this area, its healthcare staff will need to constantly monitor and document the patients capacity to self-administer their CDs, as well monitoring and documenting the actual CD self-administration. This greatly complicates matters for all.

- Questionable economic benefit
  When the costs of assessing, monitoring, re-labelling and destroying redundant CDs, etc. are considered, there is probably no financial advantage to the hospice of self-administration of CDs.

If Katharine House Hospice does not provide its inpatients with the option of self-administering their own CDs, then it needs to establish systems that ensure:

- A patient's own supply of CDs can be temporarily used for that patient only when the CDs in question are non-stock CDs.
- Patients can become sufficiently familiar with their medications and their dosage regimen before they are discharged from the hospice.

Conclusion

Having considered the arguments given above, Katharine House Hospice has decided that it will not offer its patients the option of self-administration of their own CDs during their inpatient admissions. On admission, they will be asked either to have their own CDs returned home again or to temporarily hand them over to the hospice for safe storage and reissue at the end of the hospice admission. (Any CDs that are handed in by the patient but not required for reissue at the end of the admission will be destroyed by the hospice).

The hospice is satisfied that it has systems in place that ensure:

- A patient's own supply of CDs can be temporarily used for that patient only when the CDs in question are non-stock CDs.
- Patients can become sufficiently familiar with their medications and their dosage regimen before they are discharged from the hospice.