NHS Greater Glasgow and Clyde

Mental Health Services

Inpatient Self-Medication Programme

(MHS MRG 56)

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Contents

1. Introduction

This programme is for use within Mental Health inpatient services across NHS Greater Glasgow & Clyde.

Self-medication programmes are a practical method of improving patient involvement and control of medicine administration prior to discharge from hospital. Patients should gain a better understanding of their medication while retaining or improving independence.

The main aims of the programme are:

- To establish a standard process for determining the ability of patients to take their own medication reliably and safely.
- To encourage patients to be more independent and take responsibility for their own medication within their individual limitations.
- To assess patient concordance and where necessary improve it through education and self-administration of their medication.

All patients may be considered, however, those undergoing rehabilitation into the community will be prioritised.

2. Patient Selection

The ward multi-disciplinary team (MDT) will identify patients potentially suitable for self-medication and be responsible for co-ordinating the programme for each individual patient.

The following should be considered:

- Patients should be stable on their current medication, which is not expected to change.
- Patients on regular controlled drugs, benzodiazepines or night sedation are excluded from participation in the self-medication programme. Exceptions to this are patients on controlled drugs that do not have safe custody storage and recording requirements e.g. tramadol, pregabalin, gabapentin.
- As required medicines ('prns') will not be included in the self-medication programme. As required medicines will continue to be administered at the discretion of nursing staff.
- Medication should be reviewed and, where possible, simplified prior to commencing the self-medication programme.
- Only patients who are motivated and willing to accept responsibility should participate.
- Medical and nursing staff will have knowledge of the patients' medical/psychiatric/social history, medication prescribed and be aware of the risks involved for each individual patient.
- A lockable secure cupboard must be available for each patient to store his or her medication (stage 1 of the programme and above). If individual lockable cupboards are not available alternative options involving storage within ward treatment rooms or suitable drug trolley should be discussed with Pharmacy.
- Staff must have knowledge of NHSGGC policies concerning the ordering, storage, and safe administration of medicines, as well as this self-medication policy. medicines-administration-v2-1133-update.pdf

- Patients who will be discharged to the care of services (e.g. care homes) who will administer medicines to them will be excluded.

3. Patient Assessment

An initial patient assessment for self-medication must be completed prior to commencement of the programme. (See Appendix 1)

This assessment should be conducted by the named nurse in consultation with the patient and, if available, the pharmacist.

The patient information leaflet (Appendix 2) will be provided, and more written information should be provided if required.

The assessment is then presented to and discussed by the multidisciplinary team (MDT).

The following people should normally be involved:

- Patient
- Consultant Psychiatrist
- Named Nurse
- Senior Charge Nurse
- Ward Clinical Pharmacist or Pharmacy Technician
- Occupational Therapist

The MDT will then decide if the patient is suitable to commence the programme and the decision documented on the assessment form and in the patient's chronological account of care.

When a patient is considered for the programme, following assessment and discussion by the MDT, the patient must give their written consent by signing the assessment form.

If possible, the assessment will identify the post discharge location for the patient. It is acknowledged that some care providers insist upon disposable blister packs (e.g. Dosettes) as the preferred format for supervision purposes and therefore these would be dispensed from the outset.

4. Procedure For Commencing Patients on the Self-Medication Programme

After all pre-assessment documentation has been completed the named nurse in consultation with the patient will compile a care plan, specific to their individual needs. The care plan will be reviewed and updated regularly by nursing staff.

A Medication Chart should be completed by the named nurse or pharmacist or pharmacy technician and issued to the patient (Appendix 5). This will need to be updated if medication is changed.

Supplies for self-medication will be individually dispensed for patients by the pharmacy department. Ward stock supplies should never be used for this purpose.

A pass medicines request form (pass ordering procedure) should be sent to pharmacy who will print a copy of the patient's Medicines Administration Chart (MAC) from HEPMA, detailing all the medication required by the patient to self-medicate on the ward.

The following information should also be written on the pass request form:

- ‘For self medication programme stage____’

- Request for medication supply to be repeated weekly.

- Any specific requests e.g. compliance devices (if assessed as necessary)

All patients will commence on stage 0 pending assessment.

When patients commence the self-medication programme, a note should be added to the patient’s HEPMA profile highlighting they are part of the programme and at what stage they are currently working.

Medication prescribed on HEPMA will need to be amended by a prescriber to allow for self-administration to be charted by nursing staff at medication rounds.

1. Right click on the medication prescribed.
2. Select ‘Order Modify’
3. Under ‘Medicines Management,’ select ‘will self-administer this drug.’
4. Confirm change.

This process will need to be repeated for each medication prescribed, and for newly started medication.

Where the patient is found to have problems in taking their medication, they may be held at a particular stage until the problems are resolved, and improvement is observed. They may also be withdrawn from the programme altogether. The MDT may also decide to maintain a patient at one stage indefinitely. If withdrawn from the programme, each medication will need to be amended on HEPMA again, and the ‘will self-administer this drug’ box unchecked.

The nurse in charge of the ward can decide to suspend or return the patient to the previous stage of the programme at any time of day or night. This action and the patient’s current stage on the programme must be reviewed at the next MDT meeting.

5. Stages of the Self-Medication Programme

There are four stages of the programme (summarised in Appendix 4). Patients will commence on stage 0 and progress to the next stage if appropriate following review by the MDT. The consultant and named nurse or senior charge nurse must approve a patient’s progression from one stage to the next. Stage 0 is applicable to all settings. **If individual patient medication lockers are unavailable, patients will not progress through the stages as described below but instead stage 0 will be locally adapted to reflect the facilities available in the wards concerned.**

STAGE 0: Self-administration of medication at the drug trolley under nursing staff supervision

- A seven-day pass prescription should be ordered from pharmacy, checked and securely stored in the drug trolley by nursing staff.
  N.B: Any discrepancies must be notified to the pharmacy department immediately and the medication supply returned to be re-dispensed.

- Patient should be advised to report independently to the drug trolley and administer medication under supervision.

- Administration will be monitored by nursing staff who will check, and record medication taken on HEPMA. A ‘non-administration’ drop-down menu will appear when charting, and ‘Self-Administered’ should be selected.

- During Stage 0 the nurse's electronic signature indicates they have ensured the patient has requested, selected, and taken his or her own medications according to the instructions on the label, which must be consistent with HEPMA.

- Should the patient fail to request medication at the due time, the nurse should seek out the patient, assess and document the reason for failure and administer the appropriate medication. Any failure to request medication should be referred back to the MDT.

- A follow-up assessment report (Appendix 3) should be compiled by the Named Nurse for discussion at the MDT meeting prior to the patient moving on to stage 1. This assessment should include assessing competence in managing medication and any dexterity problems. If there are any identified problems during Stage 0, consideration should be given to referring to the pharmacist and/or the occupational therapist for advice/input.

STAGE 1: Self administration of medication, stored in locker, key requested at appropriate times, medication supervised by nursing staff.

Wards with access to individual patient medication lockers

- A seven-day pass prescription should be ordered from pharmacy, checked and securely stored in the patient's individual locked cupboard.
  N.B: Any discrepancies must be notified to the pharmacy department immediately and the medication supply returned to be re-dispensed.

- The patient must approach nursing staff unprompted at the appropriate times, request the key for their locker, escort nursing staff to the locker, select the required medication and administer under nursing supervision. The key should then be handed back to nursing staff.

- Administration will be monitored by nursing staff who will check, and record medication taken on HEPMA. A 'non-administration' drop-down menu will appear when charting, and 'Self-Administered' should be selected.

- During Stage 1 the nurse's electronic signature indicates that the nurse has ensured the patient has requested, selected, and taken his or her own medications according to the instructions on the label, which must be consistent with HEPMA.

- Should the patient fail to request medication at the due time, the nurse should seek out the patient, assess and document reason for failure and administer the appropriate medication. Any failure to request medication should be referred back to the MDT.

- Keys for self-medication lockers **must be stored securely** in appropriate location within the ward e.g. a self-medication box in the drug trolley in the treatment room.

STAGE 2: Self administration of medication, stored in locker, key requested in the morning and held on person all day, medication supervised by nursing staff.

- A seven-day pass prescription should be ordered from pharmacy, checked and securely stored in the patient's individual drug cupboard by nursing staff.
  N.B: Any discrepancies must be notified to the pharmacy department immediately and the medication supply returned to be re-dispensed.

- Patient requests key for locker in the morning and keeps on person all day.

- The patient reports to nursing staff prior to accessing medication, nursing staff escort patient to their locker and the patient selects their medication whilst being supervised.

- Administration will be monitored by nursing staff who will check, and record medication taken on HEPMA. A 'non-administration' drop-down menu will appear when charting, and 'Self-Administered' should be selected.

- During Stage 2 the nurse's electronic signature indicates that the nurse has ensured the patient has requested, selected, and taken his or her own medications according to the instructions on the label, which must be consistent with HEPMA.

- Should the patient fail to request medication at the due time, the nurse should seek out the patient, assess and document reason for failure and administer the appropriate medication. Any failure to request medication should be referred back to the MDT.

STAGE 3: Self administration of medication, stored in locker, patient always has key on them, no regular supervision by nursing staff, only spot checks.

- A seven-day pass prescription should be ordered from pharmacy, checked and securely stored in the patient's individual drug cupboard by nursing staff.
  N.B: Any discrepancies must be notified to the pharmacy department immediately and the medication supply returned to be re-dispensed.

- The nurse creates a patient note on the patient's HEPMA profile to document when supplies were given to the patient. This should be updated each week with each supply.

- The patient takes his or her own medication without observation or supervision from a nurse.

- At each medication round on the ward, HEPMA will prompt nursing staff to administer medication as normal. This should be documented as 'Self-Administered' under the 'non-administration' drop-down menu as before

- Patient should be encouraged to use the Patient Medication Tick Chart (Appendix 6) to document when they have taken their medication, using their Medication Chart (Appendix 5) to aid them.

- Spot checks must be conducted at nurses' discretion at least twice per week to monitor patient compliance. Each spot check must be recorded on HEPMA under a patient note. Record of spot checks and the result should also be noted in the patient's chronological account of care. A spot check involves counting the number of tablets and checking that this is the correct amount for the remainder of the week. If the patients' medication is in a blister pack the spot check should also ensure that the remaining days and times are correct.

- During spot checks, if any discrepancies/missed doses are identified they must be clearly documented in the patient's notes on HEPMA and in their chronological account of care. It is not currently possible to amend a dose that has been missed by the patient when it has already been documented as 'self-administered' on HEPMA.

STAGE 4: Self administration of medication, stored in locker or suitable alternative, patient always has key on them, no regular supervision by nursing staff, only spot. checks. Patient picks up supply from pharmacy. This will only be possible if there is a mental health pharmacy dispensary on site

- As Stage 3, but patient collects supply of medication from the pharmacy department. This is only possible if there is a pharmacy department or clinical office on site and collection from those is assessed as safe and appropriate.

- The decision to move to this stage should be risk assessed on an individual basis.

- Prior to this stage, the patient must be taken to the pharmacy to orientate them to the department and introduce them to pharmacy staff.

- Each time the patient presents to pharmacy to collect their medication, they should take the medication supply and receipt form (Appendix 7). The staff member at pharmacy supplying the medication will sign to state that medication has been given to the patient and the patient will sign in receipt of the medication.

- When patient returns from pharmacy with their supply of medication, nursing staff must sign the form to receive medication and in doing so, must check the contents to ensure that the medications and directions on the label correspond to what is prescribed on HEPMA.
  N.B: Any discrepancies must be notified to the pharmacy department immediately and the medication supply returned to be re-dispensed.

6. Changes to Medication

Pharmacy should be notified immediately of any changes or discontinuations to a patient's medication. Once notified, pharmacy staff will print an updated copy of the patient's Medicines Administration Chart from HEPMA.

If any medication changes are made before the next supply is due (usually every Friday), the following should apply:

- Consider if the change is urgent or can wait until the next self-med supply is due.

- Dose increases and or new medication added for patients who receive their self-meds in disposable blister packs **and** for patients that receive their self-meds in skillets/bottles - a new labelled supply in skillets/bottles giving a top-up dose or a supply of the new medication will be provided, that should last until the new weekly supply is sent.

- Dose decreases for patients who receive their self-meds in skillets/bottles – will receive a new labelled supply with the decreased dose that will last until the new weekly supply is sent. The skillet/bottle containing the old dose should be removed by nursing staff and placed with the "returns to pharmacy" items, prior to being returned to pharmacy for destruction.

- Dose decreases for patients who receive their self-meds in disposable blister packs - nursing staff should remove the disposable blister pack and place it with their "returns to pharmacy" items, prior to being returned to pharmacy for destruction. The self-medication program should be suspended until the new amended weekly supply is received from pharmacy (usually every Friday). The patient should have their medication administered by nursing staff from ward stock supplies until the new disposable blister pack is received.

- Discontinued medication for patients who receive their self-meds in skillets/bottles, – nursing staff should remove the discontinued medication skillet/bottle from the patients supply and place it with their "returns to pharmacy" items, prior to being returned to pharmacy for destruction.

- Discontinued medication for patients who receive their self-meds in disposable blister pack – nursing staff should remove the disposable blister pack and place it with their "returns to pharmacy" items, prior to being returned to pharmacy for destruction. The self-medication program should be suspended until the new amended disposable blister pack weekly supply is received from pharmacy (usually every Friday). The patient should

have their medication administered by nursing staff from ward stock supplies until the new disposable blister pack is received.

- Patients with medication changes, who are leaving the ward to go out on pass – please contact pharmacy and arrange for the current self- medication supply to be returned to pharmacy for re-dispensing. The changes will be made and a new supply issued.

- All the above changes will be made subject to stock availability and usual workload /delivery cut-off times.

A change in the stage of the programme may be notified to pharmacy by telephone.

Nursing / Medical staff must never make any amendments to the dispensed medication supply. If a change is required pharmacy must be notified.

Where continual changes to a patient's medication are necessary, for example if the patient is acutely ill, the self-medication programme should be suspended until the prescribed medication stabilises again.

7. Keys and security

Patients must be encouraged to keep their key safe (stages 2 onwards). If a patient loses their key, consideration must be given to moving back to the previous stage of the self-medication programme.

Loss of medication must be reported to the nurse in charge who will investigate and take appropriate action. Depending on the circumstances, this may include contacting the on-call senior charge nurse, pharmacist, or the police.

8. Passes and discharge

Passes

Medication labelled and supplied to self-medicating patients may be used as pass medication and **must** be brought back to the hospital on return from pass.

Alternatively, pass medication for the duration of the pass can be ordered from pharmacy if there is risk of patient not bringing medicines back to the ward following a period out on pass.

Discharge

A community pharmacy must be identified with capacity to provide ongoing weekly or monthly supplies on discharge, especially for patients using disposable blister packs.

As clozapine will continue to be dispensed from Leverndale pharmacy on discharge, patients using disposable blister packs receive clozapine in one device and their remaining medicines in another device.

Appendix 1

Initial Patient Assessment

(To be completed by named nurse prior to Stage 0)

Patient's name	CHI number	Ward	Named Nurse	Consultant

Self–medication assessment checklist	YES	NO
Has the self-medication programme been discussed with the patient?		
Has the self-medication information leaflet been given to the patient?		
Is the patient agreeable to commencing the self- medication programme and signed the agreement? (overleaf)		
Is the patient stable on their current medication? (i.e. the medication is not subject to continual change)		
Can the currently prescribed medication be simplified prior to commencing the programme?		
Can the patient read and understand instructions on medication labels?		
Can the patient open medication bottles / packs?		
Does the patient have poor eyesight, reading difficulties or unable to read standard labels?		
Does the patient have a lockable cupboard suitable for the storage of medicines?		

Patient's understanding and views of their medication	**YES**	**NO**
Do you know what your medicines are for?		
Do you understand how to take your medicines?		
Do you know the number of prescribed medicines you are taking?		
Would you like more information about your medicines?		
Do you have any concerns about your medicines?		

Consider referring to the pharmacist prior to commencing self medication.

ADDITIONAL INFORMATION

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ASSESSMENT REPORT (for report back to the MDT)

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SPECIFIC REQUIREMENTS (e.g. non-child proof containers)
NB the assessment for compliance aids will take place during Stage 0

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Assessed by: …… (Nurse's signature) Date: ……

The initial assessment must be discussed by the multi-disciplinary team who will then decide if the patient is suitable to commence the programme.

SELF MEDICATION PROGRAMME APPROVED YES / NO

MEDICATION PROMPT SHEET PROVIDED YES / NO

Date of commencement of programme: …….

AGREEMENT OF PATIENT

I …… agree to join the self medication programme.

Signed: …….

A completed pass medicines request form with details of the stage of the self-medication programme with any specific requests should be sent to the pharmacy department as soon as possible. A copy of the patient's Medicines Administration Chart will be printed from HEPMA by pharmacy staff.

Appendix 2

Patient information on Self-medication programme

Self-medication is a programme allowing patients in hospital to be responsible for taking their own medication in the ward. To do this, staff will give you as much information, help and supervision as you need.

Through this programme we aim to help you:

- Keep or reclaim some of your independence during your stay in hospital.
- Understand the purpose of your medication and how to take it safely.
- Explain any changes in your medication.

You will have the opportunity to discuss with your named nurse exactly what self-medication involves and what the possible benefits will be for you. If you decide not to participate, a nurse will give your medication to you from the trolley in the usual way.

If you would like to begin the programme, your named nurse, doctor, or pharmacist will:

- Explain self-medication to you more fully.
- Explain what medication you are taking and what it is for
- Explain how often you should take this medication.
- Advise you of any possible side effects.
- Give you a chart which lists all your medications and when to take them.

Your nurse will complete an assessment process with you. This enables us to check your understanding of your medication and if you can take it without any problems. Your ability to take medication will be monitored and help offered where appropriate.

You will be asked to sign a consent form to confirm you agree to start the programme.

Your supply of medication will be labelled for you and must only be taken by you.

If you are supplied with your own medication, this must be stored in your designated individual locked cupboard.

Remaining on the self-medication programme will be at the discretion of your clinical team. There may be circumstances where the self-medication programme is suspended or halted at a particular stage.

If you have any questions please talk to your named nurse, the nurse in charge, or ask to speak to the pharmacist.

Appendix 3

Follow-up Assessment (to be completed during Stage 0)

Patient's name	CHI number	Ward/Unit	Named Nurse	Consultant

Does patient have any difficulties with the following?	Yes	No	N/A	Additional information and action required
Opening tablet bottles (child resistant containers)				
Opening boxes				
Opening foil blisters				
Using inhalers				
Reading labels (font size)				
Reading/ understanding English				
Understanding instructions				
Swallowing tablets				
Other				

Reassessment of patient's understanding and views of their medication	YES	NO
Do you know the number of prescribed medicines you are taking?		
Do you understand how to take your medicines?		
Do you know what your medicines are for?		
Would you like more information about your medicines?		
Do you have any concerns about your medicines?		

Feedback to the MDT and action points

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Assessed by: ……. (Nurse's signature) Date: …….

Appendix 4

Stages of the Self-Medication Programme

STAGE	WEE	ADMINISTRATION METHOD	RECORDING METHOD

	K NO.*		
0 **Suitable for all locations**	1 -2	▪ Medication administered by nursing staff from drug trolley.	▪ Supply from pharmacy checked by nurse prior to storing in drug trolley. ▪ Recorded on HEPMA as self-administered (available under the 'non-administration' drop-down menu in the charting screen)
1 **Only possible for sites using individual locked cupboards**	3-6	▪ Medication is stored in the patient's individual locked cupboard. ▪ Patient requests key and selects and administers their own medication at the appropriate times under supervision from a qualified nurse. Key is handed back to nursing staff after medication is administered.	▪ Supply from pharmacy checked by nurse prior to storing in locked cupboard. ▪ Recorded on HEPMA as self-administered (available under the 'non-administration' drop-down menu in the charting screen)
2	7-10	▪ Medication is kept in the patient's individual locked cupboard to which the patient has a key. ▪ Patient requests key in the morning and keeps on their person all day. ▪ Patient alerts staff when they are due to take their medication and selects and administers their own medication at the appropriate times under supervision from a qualified nurse.	▪ Supply from pharmacy checked by nurse prior to storing in locked cupboard. ▪ Recorded on HEPMA as self-administered (available under the 'non-administration' drop-down menu in the charting screen) ▪
3 & 4	11+	▪ Medication is kept in the patient's individual locked cupboard to which the patient has a key. ▪ Patient holds key permanently and takes their medication without supervision. ▪ Spot checks on medication and compliance are conducted by nursing staff a minimum of twice weekly.	▪ Supply from pharmacy checked by nurse before issuing to patient. ▪ Nurse records on HEPMA in patient's notes that supply has been given, amount of supply and the date of supply. ▪ Spot checks are recorded on HEPMA and in patient's chronological account of care. A patient note should be added to the patient's HEPMA profile and updated with each spot check.

			▪ Patient is encouraged to use medication tick chart to document when medication has been taken.

***Each patient will only progress through the stages once competence has been assessed and agreed at existing stage by the multidisciplinary team. The time limits are a guide to the amount of time a patient should remain on individual stages prior to progression to the next stage.**
There may be circumstances where a patient may progress through the programme more quickly or slowly and this decision should be made by the multidisciplinary team.

Appendix 5

Medication Chart

Patient Name: **CHI Number:**

MEDICINE	DOSE	TIME OF DAY				TYPE / REASON FOR MEDICINE
		MORNING	LUNCH	DINNER	BEDTIME	

Appendix 6

Patient Medication Tick Chart

Patient's name	CHI number	Ward/Unit	Named Nurse	Consultant

Regular medication: record in first column of the table. Date: record in each row above medication times.

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After you have taken your medication, tick beside each medicine and time.

Date and time medicines are taken																												
Date →																												
Regular medicine	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Morning**	**Lunch**	**Dinner**	**Bedtime**

Appendix 7

Medication Collection and Receipt Form

Patient's name	CHI number	Ward/Unit	Named Nurse	Consultant

Date	Supplied by pharmacy (signature)	Received by patient (signature)	Received and checked on ward by nursing staff (signature)