Heart of England NHS
NHS Foundation Trust

MEDICINES MANAGEMENT PROCEDURE

Procedure for Patient Self- Administration of Medicines in Adults v1.0

CATEGORY:	Medicines Management
CLASSIFICATION:	Procedure
PURPOSE:	Use of this procedure is restricted to those clinical areas that have been authorised by appropriate matron/head nurse to implement the self-administration procedure. This procedure applies to all Registered Nurses, Medical Staff and Pharmacy staff within HEFT. All patients who are self-administering have had the assessment completed for adult In-Patients for 'Self-Administration' or 'Self-Administration of Insulin' and this document is signed.
Version Number:	1.0
Sponsor:	Tania Carruthers, Clinical Director, Pharmacy
Approved By:	Medicines Management Group
On:	08/03/2017
Review Date:	08/03/2020
Distribution: • **Essential Reading for:** • **Information for:**	All Registered Healthcare Practitioners who are involved in the prescribing, dispensing and administration of medication to Adult in-patients (over the age of 16 years nursed on an adult ward)

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In a hurry? Click these links

Toolkit 1 Self-Administration Agreement Low Risk Medicines
Toolkit 2 Self-Administration Agreement for All Medication
Toolkit 3 Self-Administration Patient Leaflet
Toolkit 4 Review of Self–Administration Assessment Tool
Toolkit 5 Self-Administration Recording on EP
Toolkit 6 Self-Administration Patient Notice

Always read the full policy before the first time you use it.

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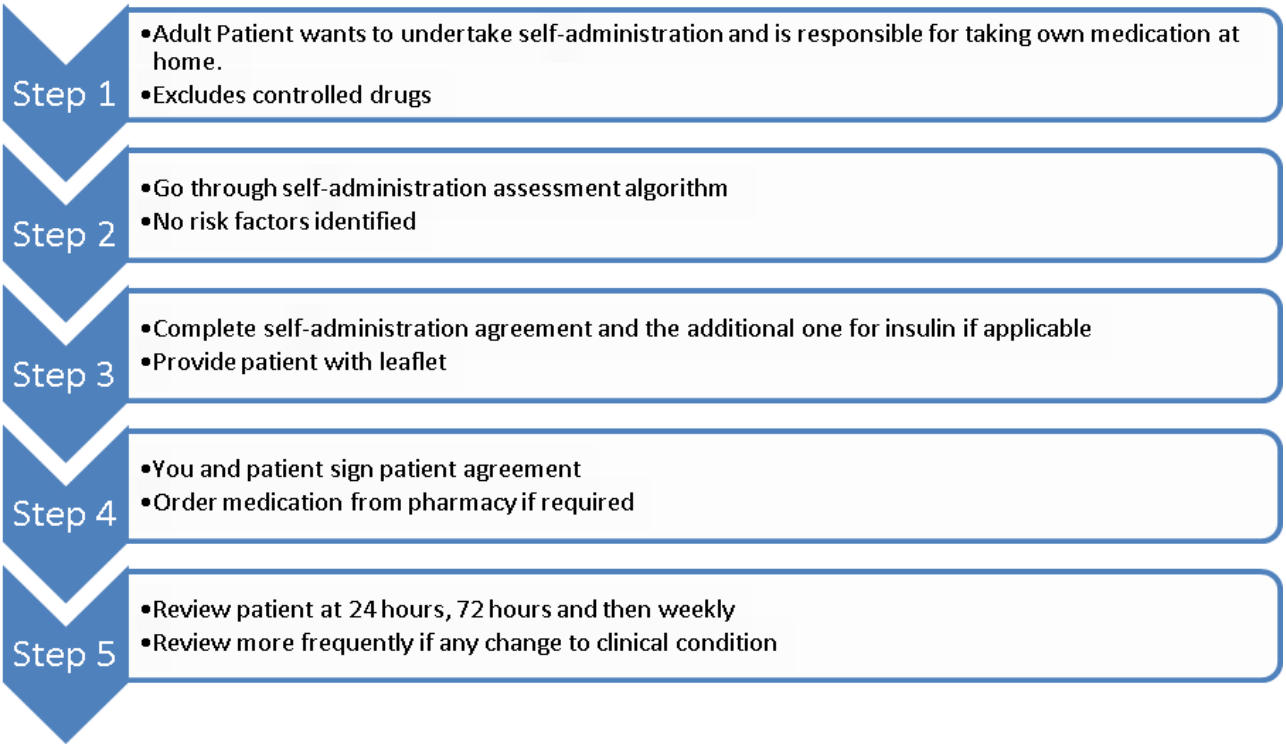
Toolkits 1-6 – Click These Links

1 Summary Flowchart for Self Administration of Medicines



2 Circulation

This Procedure is applicable to all Registered Healthcare Practitioners (RHPs) who are involved in the prescribing, dispensing and administration of medication to Adult in-patients (over the age of 16 years nursed on an adult ward); whether employed on a substantive or temporary contract with Heart of England NHS Foundation Trust (HEFT).

3 Scope

3.1 Inclusion

- All In-patients who are over the age 16 years **and** nursed within an adult setting can be considered for self-administration. If they
    - Are on regular pre-admission medication
    - Have no risk factors that would make self-administration of medications unsafe
    - Can demonstrate the necessary knowledge and skills for self-administering their medications and would usually undertake this activity at home

- Pre-Admission Medication suitable for self-administration includes;
    - Oral Medication tablets/ liquids
    - Insulin and other subcutaneous injections
    - Inhalers

- Sub-lingual sprays
- Topical Creams/Ointments
- Patches
- Eyedrops
- Nebulisers
- Rectal/Vaginal preparations
- Medication in a pharmacy dispensed blister pack (dosette box, compliance aid)

3.2 Exclusion

- Out-patients
- Inpatients who are not nursed on an adult ward
- Inpatients who are in a critical care area
- Elective caesarean section (see separate policy for self-administration for elective caesarean sections)
  - Parents/Carers being responsible for administration of medicine to the patient.
  - The following medication/ route of administration are deemed not suitable for self-administration.
    - Once only drugs
    - Warfarin
    - Intravenous Medication (exception see Policy for Cystic Fibrosis IV medication)
    - All Schedule 2 and Schedule 3 controlled drugs e.g. morphine, Herbal/Homeopathic medicines

4 Definitions

Medicine self-administration: when a patient takes responsibility for taking or using a medication as prescribed by a doctor or non-medical prescriber (NMP).

5 Reason for development

- The purpose of this procedure is to provide clear guidance on the management of patient self-administration of medication. It recognises medicines self-administration for certain patients is an important aspect of their care process. For some, it respects the patient's treatment as individuals. For others, it gives the opportunity to self-administer in the acute setting and according to clinical need. Self-administration promotes empowerment as well as an understanding of the indication for the prescribed medicine.

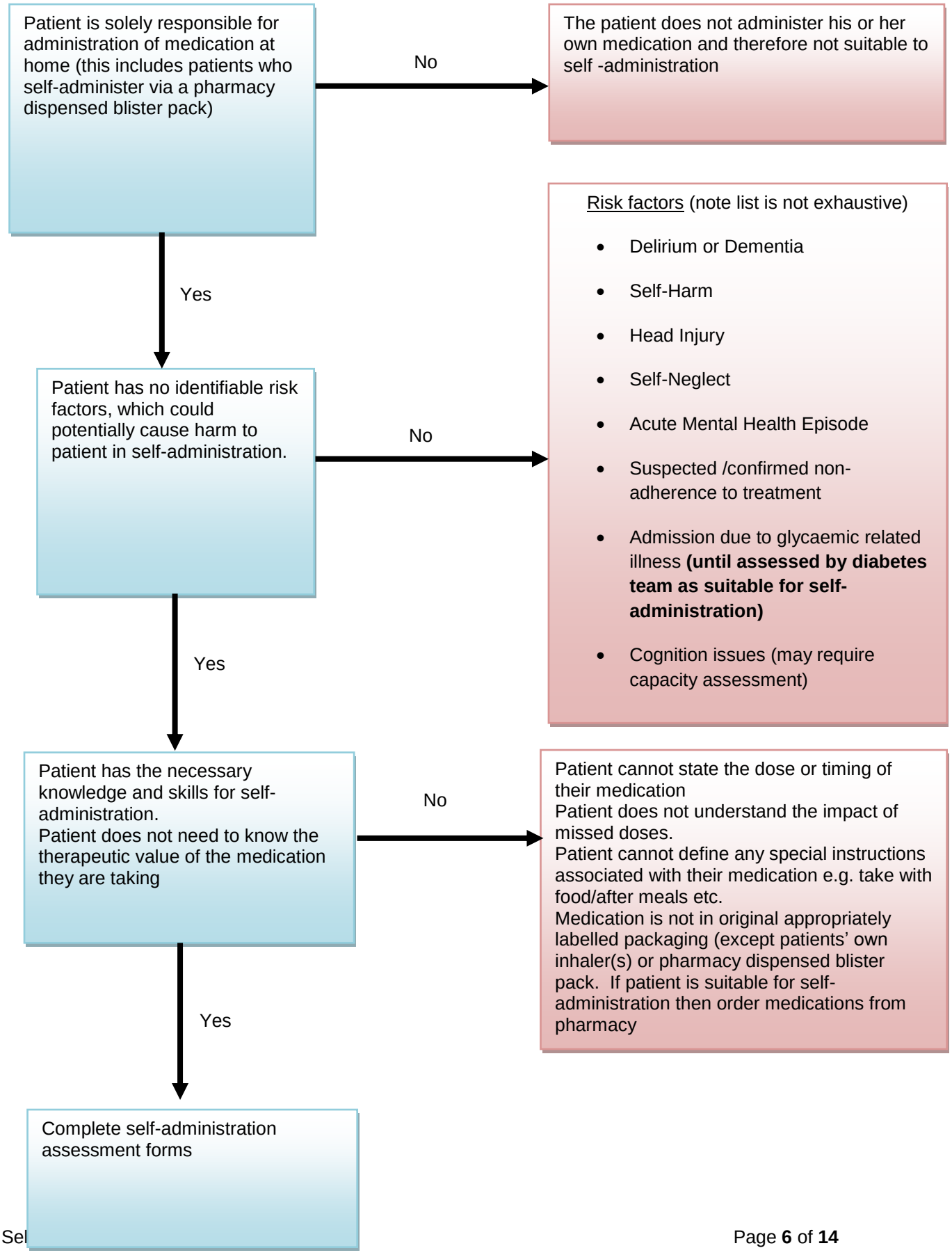
- The Government has also set objectives and recommendations with regards to the key role of self-administration programmes in optimising medicines management. The recommendations can be found in;

  - The National Service Framework (NSF) for Older People 2001
  - National Patient Safety Agency- Passport to Safer Use of Insulin 2012
  - Type 1 guidelines NICE (NG17) 2015
  - Medicines Optimisation Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guidelines [NG5] 2015

6 Aims and Objectives

- To provide patients and staff with clear guidance on matters relating to the management of self-administration of medication
- Provide a holistic humanitarian approach to patient care by allowing patients to retain responsibility for their own medicines whilst in hospital, so they can exercise some control over their own health care and support medicines optimisation
- To promote patient empowerment and improve understanding of prescribed medicine
- To identify patients with potential compliance problems
- To improve pharmaceutical discharge planning as medication management problems and solutions will have been identified early in a patient's stay and this information can be communicated to primary care in a timely manner.

7 Self-Administration of Medication Assessment Algorithm



Standard Operational Procedure for Self Administration of Medication & Insulin for Adult In-Patients

To ensure safe, effective and timely administration of medication

STANDARD	RATIONALE
***Registered Healthcare Practitioners (RHPs) Competence & Accountability** Only RHPs are competent to administer medication or are legally able to prescribe medication can assess patients for self-administration of medication. The RHP undertaking the assessment to determine if the patient is able to meet all of the criteria for self- administration is accountable for the decisions they make.	All RHPs must be able to demonstrate they have the necessary knowledge and skills to assess patient for self-administration. They must work within the policies of the organisation and be accountable to their own Professional Body.
Patient Consent All patients should be given written information in relation to self-administration of medication or insulin and be able to discuss any concerns with an appropriate RHP to ensure they are fully informed prior to making a decision on self-administration.	All patients must be able to make informed decisions about their care. The RHP has a responsibility to ensure the patient has access to both written and verbal information. Consent Policy
Self-Administration Assessment of inhalers/sublingual sprays and topical creams Patients who are admitted and already use an inhaler/ sublingual spray/ topical cream and wish to continue to take responsibility for these medications should sign Self-Administration Agreement . This agreement is valid for the duration of the patient's stay in hospital.	It is current practice for these medications to be available at the bedside. These should be placed in the bedside locker but don't require to be locked in the bedside medicine locker.
Self-Administration Assessment of all Medication All patients should be assessed using the Patient Self-Administration Tool. The RHP must ascertain if the patient has any of the risk factors which would prevent the patient self-administering. The patient must be able to demonstrate knowledge of their pre-admission medication which includes the dose, times of medication any special instructions when taking medication**.** **The patient does not need to have a pharmaceutical knowledge of their medication** (e.g. knowing exactly what the medication does is not necessary) The patient must sign the assessment tool to state that they accept responsibility for administration of their own medication. **If no signature obtained the patient cannot undertake self-administration.** The agreement is valid only for the duration of this episode of inpatient stay unless there is decision to stop the patient self-administering. It is recognised that RHPs will need to use their professional judgement. The RHP can decide that the patient is appropriate to self- administer part or all of their medications. Some potential examples of these include; • insulin but not their regular oral medications • all medications but not the nebulisers if requires assistance with nebuliser equipment **Self-Administration Assessment of Insulin** In addition to above the patient must be able to demonstrate knowledge of dose and timing of their insulin, what to do if a dose is missed, understands that changes to food can affect glucose levels, knows own target blood glucose range, can describe & explain rationale for dose adjustments, recognise and treat hypos, understands safe disposal of sharps & blood products. Where appropriate the patient should be referred to appropriate team e.g. Diabetes Inpatient Specialist Nurses to address issues regarding knowledge	It is the responsibility of the RHP to ensure the patient meets the criteria for self- administration of all of their medications, their insulin or just their inhalers/sublingual sprays The patient needs to be able demonstrate an awareness of the dose. timings and any special instructions of their medications The patient will need to be reassessed for self-administration for any future admissions as this agreement is only valid for their current admission. It is the responsibility of the RHP to ensure the patient meets the criteria for self- administration of insulin.

STANDARD	RATIONALE
Communication amongst Healthcare Team The RHP must sign the assessment tool to indicate patient has met the criteria and document this in the medical notes. The following actions should then be undertaken; -inform the medical and pharmacy team the patient is undertaking self administration -the medical team are responsible for adding a note on the patient's electronic prescribing drug chart to confirm self- administration status or where paper charts are in use a visible alert (on the front of the patient's prescription) should be written -complete the patient notification sign and fix to patient medicine locker -communicate at Patient Handover/ Safety Huddles/Board Reports that the patient is participating in the self- administration process. -Wherever e-JONAH screens are in the use the RHP must ensure the identified icon is assigned to the patient's details. Patients who do not meet the criteria must be informed verbally and the decision recorded in the patient's medical records along with the completed assessment tool.	The RHP undertaking the assessment is accountable for ensuring the information is disseminated amongst the clinical team. If the assessment is undertaken by a Doctor/Pharmacist it is reasonable to inform the Nurse in Charge and for the Nurse in Charge to disseminate the information to rest of the nursing team through the normal communication process (nursing handover/ safety huddles)
Use of Medicine Lockers Only approved medicine lockers can be used for storage of medicines. All medicines lockers must be lockable and the patient will be responsible for the safe custody of the locker key/security key code (where individual locker keys are available). **Under no circumstances must patients be issued with a master key**. The patient must ensure the locker is secure at all times and the key is kept on their person. If the patient is to leave the ward for any reason they may hand the key to the nurse responsible for their care at that time. The patient must also be advised not to give the key to another patient/ relative or anyone other than a ward nurse. **Lost or misplaced keys must be reported immediately.** Where individual locker keys are not available the nurse remains responsible for the safe storage of medicines and the patient advised to request medicine from the nurse	All medicine lockers must be fit for purpose. If any lockers are damaged or have broken keys this must be reported to estates for repair. Any locker that is considered damaged must not be used, if available an alternative locker should be sought for the patient. If no replacement locker is available then the drugs will need to be stored safely and the patient advised to request medicine from the nurse. **Under no circumstances can medicines (other than** inhalers/ sublingual spray/ topical creams **be kept in the patients clothing locker**
Lost Medicine Locker Keys When patients report a lost locker key every effort must be undertaken to find the key. When the key cannot be found an IR1 must be completed and a replacement key ordered. If the patient has inadvertently taken the key home with them on discharge every effort must be taken to retrieve the key from them, the ward must contact the patient by phone and request the key to be returned either in person or their nominated adult (preferred option) or via the postal system. The patient must state their name and their date of discharge so this can reconciled against the ward data.	The safe and secure storage of medicines is paramount. Every effort must be made to have lockers keys returned upon discharge. The ward must have a clear process for contacting the patient to have the locker key returned within 2 days
Medication RHPs may use patients' own medicines (POD) in accordance with the guidance in standard 2 and 3 of the NMC Standards for Medicines Management. If the medicine is not suitable for use or the instructions on the dispensing label do not exactly match the prescription then the patients' own medicines should not be used. A pharmacy dispensed dosette box (blister pack) can be used provided the labels match the inpatient prescription and that it has been dispensed within the last 6 months Stock medicines should not be placed in the patient's medicine locker as they are not labelled for that individual patient. Where necessary order the required medicine(s) from pharmacy and ensure that the request indicates that the patient is self- administering.	Assessment of patient's own medicines (POD) to ensure that medicines are suitable for use in hospital. NMC Standards for Medicines Management can be accessed; http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-for-medicines-management.pdf If patient has not brought in medication or POD is not suitable for use then medicines should be ordered promptly from pharmacy to ensure no delay or omitted medicine doses.

Medication will be stored in individual lockable cabinets at bedside except those that need to be stored in a refrigerator (and removed on patient prompt); these should be kept in the ward fridge, and reliever inhaler devices/sprays, topical creams/ointments which may be kept at bedside.	If a patient is on a blister pack and the medication has changed during the admission then the patient will not be able to self-administer from a blister pack.
STANDARD	**RATIONALE**
Review of Insulin treated patients Patients who are self-managing their diabetes may be able to test their blood glucose, using their own equipment.. Further information is available in the Capillary Blood Glucose Monitoring Procedure Patients who are self-monitoring should make the results of tests available to nursing staff, however clinical staff should only make treatment changes using blood results taken with a trust approved and quality-controlled meter. Any readings <6mmol or >10mmols should be taken/retested on a ward meter by a Healthcare Professional (HCP). If a dose range of insulin has been prescribed (e.g. for patients who are carbohydrate counting or on a continuous subcutaneous insulin pump) then the nurse should check with the patient what dose of insulin has been given and record this on the administration section of the paper prescription or add a note to the electronic prescription.	It is important that the patient is given the opportunity to monitor their blood glucose levels using their own equipment. However no treatment changes should be made without confirming blood sugars with ward blood glucose meter
Recording self-administration The patient will have named-patient medicines with printed directions in their allocated locker and administer own medicines without nursing involvement. The nurse will verbally check the patient has taken their medication due at medication administration times and record self- administration on EP or the drug chart (or on paper charts denoted by the number 5. The nurse has not witnessed the administration, therefore is not appropriate to sign the drug chart.	Provided the RHP is satisfied the patient meets the criteria for self-administration and the above appropriate paperwork completed then the patient will take full responsibility for safe storage and administration
Review dates All patients should have the self-administration process reviewed within the given timescales (within first 24hrs then at 72hrs and thereafter weekly) as a minimum standard and recorded on the self -administration review record. The self-administration review record must be completed	Due to changes with patients' medical conditions and on-going treatment, patients must be reviewed to ensure it is appropriate to continue with self-administration. Review can occur more frequently than the given timescales stated if necessary.
Changes to Prescribed Medication **It is the responsibility of the prescriber to inform the patient and the nursing team when changes have occurred to the prescribed medication.** **The ward must have a process to inform pharmacy that medication has been altered so labelling of medication can be altered.** The prescriber must record either in the medical records (for paper charts) or within the EP system what changes have occurred and who has been informed. For new medication, dose changes or medication the patient is not confident with, the following information should be provided by the nurse before self-administration begins: • The name of the drug • Why they are taking it • Method of administration • Dose and frequency • The dose in relation to food (if appropriate) • Possible side-effects This counselling procedure should be supported by reference to the medicines information leaflets for the appropriate drug and indication. (These will be available on the ward, or on request from the ward pharmacist or Medicines Management Technician.)	All Medical and NMPs are responsible for informing both the patient and the Nurse in Charge when any amendments have been made to the patient's prescription. Medicines Policy
Patient Transfer All patients undertaking self-administration that are transferred to a new clinical area **must** have a self- administration review undertaken and this must be recorded on the self- administration record.	As per HEFT Patient Transfer Policy All patients needs to be re-assessed before medication can be taken.

STANDARD	RATIONALE
Rationale for removal of self- administration Patient may be removed from the self- administration process if there is a change in their clinical condition whether for a short term (e.g. undergoing surgery) or permanent suspension from self- administration or at the patient's own request to withdraw from the process. Patients have the right to decline the option of self- administration and request to be withdrawn from self- administration at any time during their admission. The RHP who has removed the patient is responsible for updating the patient's prescription chart (paper or electronic prescription). They must also ensure that this is medical records Inform nursing team so the information is then disseminated via patient handover. Remove the icon from e-JONAH if in use. If reason for removal is clinical decision ensure patient is informed In all circumstances the medicine locker key should be removed from the patient. **Medication can remain within the locker though** If suspension is temporary, agree a review date for further assessment.	Any patient who no longer fulfils the criteria for self-administration or wishes to be removed must be removed immediately, whether this is temporary or a permanent removal. All HCPs must ensure that medication is administered as per HEFT Medicines Policy
Patient Discharge The discharging nurse is responsible for ensuring the key is returned and the medicine locker is emptied of all medication at the point of discharge. Any medication not required for discharge must be returned to pharmacy or if it is medication the patient has brought in , seek permission from the patient to dispose of it	Ensure that patient's safety is maintained and that lockers only contain medicines for that individual patient
Missed/Incorrect dose/Over dose of Medication If the patient has missed a dose of their medication they must be advised they should inform the nursing staff this has occurred **immediately.** The patient must be assessed as whether it is appropriate for the patient to take the medication at a later time or to omit the dose completely. All decisions must be discussed with the patient and recorded within the patient's medical records and a note added to the patient's prescription (either paper or EP). If necessary the patient should be reviewed for continuing on the self-administration process. If a patient has taken more medication than prescribed the Doctor must be informed and the patient reviewed The clinical team should establish why the incorrect/overdose has occurred. The patient should be reviewed for continuing on self- administration and if necessary have the self-administration approval revoked. **All patients' missed doses, incorrect doses or overdoses on self-administration require an IR1 to be completed**	Ensure patient's safety is maintained. Manage any medication error as indicated in HEFT Medicines Policy Where it is necessary complete an IR1 Form and follow HEFT Reporting Process

***** Registered Healthcare Practitioners= Registered Nurses/Midwives/Doctors/Pharmacist

8 Responsibilities

Pharmacy staff, nurses including corporate nursing and medical consultants are responsible for the development and implementation of the procedure.

8.1 Chief Executive

- The Chief Executive has overall responsibility for Medicines Management within the Trust. This is delegated to the Clinical Director of Pharmacy and includes the safe and secure handling of medicines within the Trust. The Clinical Director of Pharmacy reports directly to the Chief Executive for this purpose across the whole of the organisation.

8.2 Ward Manager

Senior sisters and managers of relevant departments must ensure that:-

- The nursing staff have read and are aware of the procedure **'Patient Self-Administration of Medicines in Adults'** from the Trust intranet via the home page.

8.3 Pharmacist/Medicines Management Staff

- Pharmacy staff must have read and are aware of the procedure 'Patient Self-Administration of Medicines in Adults' from the Trust intranet via the home page.
- Supply each patient with individual labelled medication or assess patient's own medication for suitability to use

8.4 Consultant

- Ensure that they and their team have read and are aware of the procedure in order to support patients appropriately for self-administration.

8.5 Medical Staff

- Be aware that a patient is self-administering
- For adding note to patient prescription regarding patient self-administration status
- Respect the patient's view when discussing self- administration
- Inform the nursing staff and the patient if they make a change to the prescription
- Advise the patient/nurse if there is any change in clinical condition which may impair the patient's ability to self-manage

8.6 Nursing Staff

- Assess the clinical condition of the patient to assess whether this may impair the patient's ability to self-manage
- Ensure appropriate paperwork is completed as per procedure
- Review the patient in accordance with procedure
- Order individual labelled medication for patient's if necessary to support self-administration

Directorate

- Each directorate is expected to review the relevance of this procedure for implementation in each of its clinical settings; to consult with its patients/service users on its adoption and its introduction; to ensure their patients are given a choice to self-administer their medicines while in hospital, if they are capable of doing so.

8.7 Ratifying Group Responsibilities

- Medicines Management Group and Corporate Nursing will be responsible with the Clinical Director of Pharmacy for approving, producing and distributing this procedure and monitoring any action plans arising from any serious incidents that are reported in relation to this procedure

9 Training Requirements

- All members of the clinical team responsible to the patient for providing safe and effective care should have read the self-administration procedure. In addition to the training, staff may also refer to the Nursing and Midwifery Council 'Standards for practice of administration of medicines' (August 2008), incorporating the Guidance paragraph at Standard 9: 'Where self-administration of medicinal products is taking place, you should ensure that records are maintained appropriate to the environment in which the patient is being cared for'.

- The nurses and medical staff joining the Trust will be introduced to the self-administration scheme as part of their Corporate/Clinical and local induction.

- All relevant members of staff will be identified at local level and made aware of the procedure on the Intranet site by their manager. This information includes patient recruitment, patient knowledge, teaching, supervision and supply and storage of medication.

10 Monitoring and compliance

The Monitoring and Compliance of this procedure will be carried out in line with the table below. Any deviations or incidents relating to this procedure must be reported on an IR1 form. The IR1 forms will be received by the Pharmacy Governance Manager who will review and escalate all incidents as necessary.

Criteria	Monitoring Mechanism	Responsible	Committee	Frequency
Safe & secure handling of medicines	Audit	Pharmacy Governance Lead	Medicines Management Group	Annually
Medication Incidents	Review of IR1s	Pharmacy Governance Lead	Medicines Management Group	Quarterly
Documentation of self-administration	Audit	Corporate Nursing	Safe Medication Practice Group	Quarterly
Safe & Secure handling of medicines (nursing responsibilities)	Nursing metrics	Chief Nurse & Corporate Nursing	Medicines Management Group	Monthly

11 References and Associated Documentation

- HEFT Medicines Policy 2015
- NMC standards for medicines management 2008
- NHS Education for Scotland - Toolkit for the Self-Administration of Medicines (SAM) in hospital accessed via: http://www.nes.scot.nhs.uk/media/6798/samsbrochure.pdf

- Department of Health – Self-administration of medicines in hospital accessed via: http://www.dh.gov.uk/
- Self-Administration Policy-Guy & St Thomas Hospitals NHS Trust 2012
- Self-Administration Policy- Liverpool and Broadgreen Hospital 2012

12 Meta data and Revision History

Document Title:	Procedure for Patient Self-Administration of Medicines in Adults
Status	Final
Document Author:	Natasha Jacques, Principal Pharmacist Maria Mackenzie, Corporate Nursing Shahzad Razaq, Principal Pharmacist
Source Directorate:	Pharmacy Directorate
Date Of Release:	10.03.17
Ratification Date:	08.03.17
Ratified by:	Medicines Management Group
Review Date:	08.03.20
Related documents	HEFT Medicines Policy 2015 NMC standards for practice of administration of medicines 2008 Mental Capacity Act 2005 Mental Health Act Code of Practice 2015 Department of Health – Self-administration of medicines in hospital Self- Management of Diabetes in Hospital JBDS NHS Diabetes March 2012 Type 1 diabetes in adults: diagnosis and management (NG17) 2015
Superseded documents	Update to the Policy and Procedure for Patent Self-Administration of Medicines in Adults V3.3
Relevant External Standards/ Legislation	CQC, NHSLA Risk Management
Key Words	Patient Self-Administration of Medicines, Self-Medication, Self-Administration, Self Administration,

Version	Status	Date	Consultee	Comments	Action from Comment
1.0	Approved	2/2010	Safety Committee	Approved subject to minor amendments	Policy amended accordingly
2.0	Ratified	07/2011	Drug and Therapeutics Committee	Ratified following re-format changes in-line with Policies and Procedures Framework	
2.1	Draft	March 2012	Catherine Holmes, Inpatient Diabetes Nurse Dr P.Dyer, Consultant Physician	Presented simplified assessment and level process incorporating version from Guys and St Thomas Hospital and NHS Diabetes guidelines on self-administration of insulin	Policy and patient information leaflet amended accordingly
2.2	Draft	May 2012	Dr P. Dyer Dr J.Shakher	Feedback that assessment would need to include mental capacity, cognition and memory Capacity is sufficient. Recommended set questions to guide capacity assessment	Capacity and whether policy needs to include assessment of cognition and memory to be discussed at trust Drugs and Therapeutics Committee
2.2	Draft	June 2012	Drugs and Therapeutics Committee	Capacity and whether policy needs to include assessment of cognition and memory to be discussed at trust Drugs and Therapeutics Committee	Capacity determined as sufficient for this policy
2.2	Draft	June 2012	J.Webb	Clarification of blood glucose meters Clarification of staff able to assess capacity	Policy amended

2.2	Draft	June 2012	K.Link	Clarification of ; -inclusion of subcutaneous injection -add examples of drugs liable for abuse -exclusion of herbal/homeopathic medicines -issuing key to patient -incident reports are reviewed quarterly	Policy amended
2.2	Draft	June 2012	H.Knight	Raised issue about pharmacists undertaking capacity assessment	Clarified for this policy capacity assessment can be undertaken by qualified nurse/midwife or doctor.
2.2	Draft	June 2012	T.Carruthers	To include in scope patches and eyedrops	Policy amended
2.2	Draft	June 2012	A.Holland	Add dates to references Minor wording changes	Policy amended
2.2	Draft	June 2012	A.Field	Add further information on capacity assessment	Appendix on capacity added
2.2	Draft	October2012	B.Ahitan J.Lees	Policy should include nebulisers Clarification required on who can undertake patients' own drug assessments	Policy amended
3.0	Approved	November 2012	Drugs & Therapeutic Committee	Approved subject to any minor amendments	Drugs & Therapeutic Committee Chair
3.1	Approved		N.Jacques	Addition of statement as per recommendation of Nursing and Midwifery Board	Policy amended
3.2	Approved	Nov 2013	M.McKenzie N.Jacques	Updated Appendix 1 to remove need for nurse transcribing	Policy amended and approved by Drugs and Therapeutics Nov 2013
3.3	Approved	Jan 2016	Medicines management Group (MMG) (Formerly DTC)	6 month extension to policy while quality improvement project is being completed within the Trust to review policy	Policy Date reviewed
4.0	Draft	April 2016	M.Mackenzie N.Jacques S.Razaq	Updated policy into a procedure document. Changes also made to reflect changes in mental capacity and standard operating procedure.	Procedure amended
4.1	Draft	July 2016	M.Mackenzie N.Jacques	Updated documentation in the Appendices and amended flowchart	Procedure amended
4.2	Draft	October 2016	Consultants, matrons, Chief Nurse, Deputy Chief Nurse, Divisional Head Nurses and Associates, diabetes nurses, Principal Pharmacists, Senior Sisters, Midwives, SHOs	Formatting and grammatical errors addressed Request to remove warfarin from self – administration due to variability of dose, requested accepted and added to exclusion list. Excluded Elective Caesarean Sections as existing pathway in place.	Procedure amended and sent to Medicines Management Group for ratification
4.3	Draft	Feb 2017	N.Jacques S.Razaq	Updated Toolkit 5 to include how to document on electronic prescribing self administration status Removed exclusion of PRN medications Added statement that patient can request to withdraw from self-administration on self-administration agreement form As per feedback from Dr Sharon Jones- addition of inclusion of patient with primary glycaemic problem once assessed by diabetes team Corporate nurse team consulted and no further changes required	Procedure amended and sent to Medicines Management Group for ratification
4.4	Approved	March 2017		Approved by Medicines Management Group	