Safer delivery of dispensed medication from community pharmacies

REPORT

Most community pharmacies offer a delivery service to their patients. For many vulnerable patients, this can be an essential service but for others, it is requested for reasons of convenience rather than specific health need. From internal reports highlighting a number of serious delivery incidents (from a patient and driver perspective), Boots UK identified a need for policy guidance on delivery issues and this topic was raised at the Community Pharmacy Patient Safety Group.

LEARN

Whilst it is evident that robust standard operating procedures (SOPs) exist for key processes in each pharmacy and for the hand over of medication at the patient's home, an opportunity to accompany delivery drivers on their shifts proved enlightening, highlighting the complexity of some delivery patients' needs and the unique challenges faced by delivery drivers. These accompanied visits inspired further cross-functional working to further understand the relevant issues and address these in a practical manner.

SHARE

A number of key delivery incidents that had occurred in Boots UK were shared (in an anonymised format) with the Community Pharmacy Patient Safety Group as part of its 'share and learn' agenda. Member organisations also provided examples of their delivery incidents, which further enhanced our understanding of the issues that needed to be addressed.

ACT

Using the anonymised delivery incidents information from the Community Pharmacy Patient Safety Group members, a series of insights was drawn up for the safer delivery of medication. Supporting case studies were circulated as examples of the evidence base that had informed these insights. The final draft was presented at a Patient Safety Group meeting and discussed in the context of its relevance and feasibility. It was agreed that the insights were appropriate and all member organisations agreed to adopt them in their pharmacy teams' practice.

REVIEW

The creation of the Community Pharmacy Patient Safety Group insights into the safer delivery of medication prompted a detailed review of our SOPs and led to the creation of specific support tools to assist pharmacy and delivery driver colleagues with their decision making. The impact of this work on delivery incidents continues to be assessed as part of our ongoing patient safety governance agenda. Subsequent review of this work identified evolving models of pharmacy service delivery to reflect patients' changing expectations. Updated guidance is provided for the management of safe deliveries when patients request their medication via the pharmacy's online service.

Safer delivery of dispensed medication from community pharmacies

An updated summary of insights from the Community Pharmacy Patient Safety Group (Jan 2020)

Definition of a community pharmacy medication delivery service

A delivery service is where medication dispensed in a community pharmacy is handed to the patient, his/her carer or other designated person at a location other than the registered pharmacy premises.

Insight 1 – Patient need for a delivery service should be established rather than presumed

Background

- The number of patients requesting a medication delivery service is increasing
- Although it is not funded in the NHS Pharmacy Contract, removal of this service would increase the burden on Social Care and damage the reputation of the profession (and the pharmacy business)
- Some aspects of medication delivery to patients' homes (e.g. depositing medication in a 'safe haven' or a designated location within the home to which the patient has no access) can perpetuate poor care and should be discontinued
- Any changes to the current medication delivery service will require a transitional period while the new service model is embedded
- Time invested in establishing (and recording) patient needs when the service is first requested will:
    - Help to reduce the number of 'failed deliveries'
    - Provide clarity to patients (and their representatives and carers) as to the scope of the service
    - Reduce the risk of pharmacy teams inadvertently perpetuating a model of poor care
- There is a requirement for pharmacists to maintain appropriate records of requests for the service

Documentation – Delivery of Medication Request Form ('Patient details' section)

Insight 2 – There is a requirement for permission to deliver medication to a patient at home

Background

- Permission must be obtained from the patient to provide the delivery service on a single occasion or for a set period of time
- If the patient cannot give informed consent (e.g. due to a lack of mental capacity), then consent must be obtained from a relative or other representative authorised to give consent on the patient's behalf (e.g. through a Power of Attorney)
- Delivery to a person other than the patient or his/her authorised carer is undertaken only if that person has been specifically designated by the patient or his/her authorised carer
- As the detail of what constitutes 'delivery of medication' is necessarily complicated by varying patient needs, consent for all elements of the service is required

Documentation – Delivery of Medication Request Form ('Consent' section)

Insight 3 – The involvement of the Responsible Pharmacist (RP) is crucial in the set-up and maintenance of the medication delivery service

Background

- On each occasion a delivery service is provided, the RP must use his/her professional judgment to determine whether direct face-to-face contact with the patient or his/her carer is necessary
- The RP must understand his/her accountability with regard to dispensed medication that is provided via a delivery service – i.e. the pharmacist still has a professional responsibility to ensure that patients (or their carers) know how to use (or administer) the medication safely, effectively and appropriately and check that the patient is not experiencing adverse effects or compliance difficulties

- Systems should be in place to ensure that a signature is obtained to indicate that the medication has been received safely by the patient (or his/her authorised representative)
- Systems should be in place to inform a patient who is not at home that a delivery was attempted
- The RP should oversee the handover of medication for delivery to the driver in the pharmacy and should encourage/empower the driver to report any concerns regarding patients (e.g. safeguarding concerns or other deterioration in their apparent health or wellbeing)
- The RP should undertake a review of the patient's suitability to continue receiving deliveries of medication periodically, as many vulnerable patients are likely to experience a decline in their physical and/or mental health over time

Documentation – Pharmacy standard operating procedures (SOPs)

Insight 4 – The patient must be able to positively identify himself/herself on every occasion If not, an alternative solution should be found for reasons of patient safety

Background

- To ensure a robust handover at the patient's home, the patient must be able to identify himself/ herself consistently and confirm his/her address
- If the patient cannot identify himself/herself consistently, other options for receipt of the dispensed medication should be considered:
    - Acceptance of the delivery by the patient's authorised carer/representative (at the patient's home)
    - Delivery to another designated person/address (as agreed under Insight 1) – e.g. neighbour, day care centre, hospice
    - Family member or other authorised representative to collect the medication from the pharmacy

This means that patients with dementia, alcoholism or any other mental health condition affecting their ability to identify themselves consistently would need to have their medication obtained from the pharmacy via an alternative route, after discussion with the GP. This is in the best interests of patient safety.

Documentation – Delivery driver standard operating procedures (SOPs)

Insight 5 – Hiding medication from the patient is not appropriate from a community pharmacy delivery service

Background

- If, for his/her own safety, a patient cannot be trusted to take receipt of his/her medication and it is requested to be placed in a 'hiding place' for the carer/representative to retrieve, then this need cannot be met by a community pharmacy delivery service
- It is not appropriate for vulnerable patients to have their medication hidden from them and for delivery drivers to have to make 'professional decisions' about whether to carry out these instructions if the patient is particularly lucid or persuasive at the time of the delivery
- This type of patient requires an alternative solution to be determined after a discussion between the RP and the GP

Documentation – Delivery of Medication Request Form ('Patient details' section)

Insight 6 – Safe havens (i.e. a lockable box outside the patient's property) should not be used for the delivery of medication

Background

- Given the need for positive affirmation of the patient's identity and the requirement for correct medication storage conditions (to prevent degradation) this is not a viable option for the safe delivery of medication to patients
- If medication was 'delivered' this way, the RP could not have confidence (with a supporting audit trail) that the medication had been received by the patient with the required promptness

Documentation – Delivery of Medication Request Form ('Patient details' section)

Insight 7 – A key safe access system may be used with the correct consent, SOPs and support for delivery drivers

Background

- After a detailed review of current service users, it has been identified that a significant number of patients receive their medication after the delivery driver has entered their home by using a key safe access code
- The physical health of these patients is such that they are unable to open the door to receive the delivery; however, they are able to identify themselves consistently and confirm their address
- With the appropriate patient consent to cross the threshold, guidance on managing atypical circumstances and suitable support for drivers, it is considered that this remains an appropriate and valuable service for some of community pharmacy's most vulnerable patients
- The RP must consider whether any particular supply of medication should be supported with a direct telephone conversation with the patient to ensure that the patient knows how to use his/her medication safely and effectively
- The RP must ensure that systems are in place to safeguard confidential information, such as key safe access codes (as well as the usual safeguards for protecting sensitive personal data)

Documentation

- **Delivery of Medication Request Form ('Patient details' section)**
- **Pharmacy standard operating procedures (SOPs)**
- **Delivery driver standard operating procedures (SOPs)**
- **Delivery driver supplementary guidance/training**

Insight 8 – Delivery to an alternative address (where the driver does not need to get back in the van) is appropriate to improve efficiency and ensure the patient receives his/her medication in a timely manner

Background

- It is accepted that, although a patient may be housebound, there could be occasions when a named authorised individual (at an alternative nearby address) could receive the delivery of medication if the patient was out, e.g. at a hospital appointment
- Patient consent for a named individual to receive the delivery at the alternative address is required and the patient should inform the pharmacy of any changes to the arrangements
- The named authorised individual would need to be made aware of the intended scheduled delivery

Documentation

- **Delivery of Medication Request Form ('Patient details' section)**
- **Pharmacy standard operating procedures (SOPs)**
- **Delivery driver standard operating procedures (SOPs)**

Insight 9 – The decision to deliver items by taxi must only be made when all the above options have been explored in full and are considered unsuitable.

Background

- Company-employed drivers are preferred for the delivery of medication to patients since:
  - They can be trained in, and required to comply with, the relevant pharmacy's SOPs
  - Additional training can be provided on key areas relevant to the role (e.g. safeguarding)
  - They will be subject to relevant company policies and processes (e.g. investigation of adverse incidents, disciplinary action, Disclosure & Barring Service checks)
  - The pharmacy owner cannot insist that taxi drivers comply with the above
- If delivery by taxi is the chosen option, the patient should be contacted to obtain consent for the delivery of the item(s) via this method
- The RP should consider the suitability of the individual driver, in the context of his/her behaviour, communication skills and level of engagement with the importance of the task on arrival at the pharmacy
- The taxi driver should be given clear instructions that the delivery must be to the patient (or his/her nominated representative only) and cannot be posted through the letterbox or left elsewhere at the address or left with neighbours
- If the delivery includes a Controlled Drug, it should be accompanied by a member of the pharmacy team

Documentation

- **Record of the taxi driver's identity and licence number, together with details of the item(s), destination and the RP's reason for choosing this method of delivery**
- **The taxi driver should be provided with a means to obtain the patient's signature to confirm his/her safe receipt of the item(s) for subsequent return to the pharmacy**

- **Insight 10 – Sending medication via the Royal Mail (or other courier service) should only be considered as a last resort by general community pharmacy teams*. If this route is chosen, the medication should be packaged securely so that the contents are not obvious and the delivery signed for by the intended recipient**

Background

- Any supplies of medication via the Royal Mail (or courier service) should be sent via its 'Signed For 1st Class' service (or the courier's equivalent service) so that a signature is provided as evidence of receipt
- The RP should be involved in any decision to supply medication via this route and ensure that due consideration is given to the suitability of the medication to be supplied via this route and any risks relating to the intended recipient

*** It is acknowledged that many specialist pharmacy companies use courier services as a first choice for making deliveries; these organisations are outside the scope of this paper.**

Appendix 1 - case studies

Insight 1 – Patient need for a delivery service should be established rather than presumed

1. Mrs Trainer had 21 failed deliveries in the last year. Twelve of these related to her not being at home at the time the driver tried to deliver her medication because the pharmacy team had not contacted her to agree a delivery slot. On a further nine occasions, the pharmacy team had made arrangements with the driver to deliver to Mrs Trainer but the patient herself or one of her relatives had already collected the medicines.

   This is clearly not economical for the business and we need to do all that we can to reduce the number of failed deliveries so that we can maintain this important service for our most vulnerable patients.

2. A blister pack is delivered to Mrs Hooper every Tuesday. Today the driver tried to deliver this at 11am, ringing the doorbell several times and waiting for several minutes as usual but got no response so put a failed delivery card through the letterbox. He noted that the patient's husband's car was not in the driveway. As the patient is hearing impaired, failed deliveries are common when Mr Hooper is not there.

   Mr Hooper arrived at the pharmacy with the card at 12.15pm¸ while the blister pack was still with the driver. He said that the driver must not ring the bell as it is very loud and his wife would hear it and this level of service was not good enough and he would change pharmacy if it continued.

   It would appear that Mrs Hooper does not require a delivery service and a careful conversation with Mr Hooper may be needed so that alternative arrangements can be made for him to collect his wife's medication.

Insight 2 – There is a requirement for permission to deliver medication to a patient at home

1. A prescription was received for Mrs Foster, an elderly patient whose medication is prepared in a blister pack and we normally deliver this to her every month. Mrs Foster had moved recently from the house she shared with her son, James, to sheltered accommodation and the address on the prescription had been changed. Regrettably, this was not noticed by the pharmacy team and the blister pack was delivered to the previous address and accepted by James (as he had done on previous occasions).

   The following day, a police officer visited the pharmacy asking for information about the medicines that had been delivered to Mrs Foster. It turned out that James had taken all of his mother's medicines and his body had been found by his brother when he visited the house.

   This tragic incident demonstrates the importance of obtaining the patient's permission and only delivering to the patient or his/her carer or a specifically designated person.

2. Miss Burns-Smith needs to use a wheelchair and she has made arrangements for her medicines to be delivered to her at home. Last month, Susan, one of her carers, visited the pharmacy to buy a medicine for Miss Burns-Smith and asked the pharmacist to check that the over the counter medicine did not interact with her prescribed medication. During that visit to the pharmacy, the dispenser took a note of Susan's mobile number in case there was a query in future relating to Miss Burns-Smith's delivery.

   The next time the driver took Miss Burns-Smith's medication to her home, she was out and the pharmacist rang Susan to try to make alternative arrangements. The patient was furious

as she is only 40 and, by phoning her carer without her consent, she said that she was made to feel "invisible".

While many patients are pleased to allow family members or carers to make delivery arrangements on their behalf, it is important to ensure that the patient has provided appropriate permission.

Insight 3 – The involvement of the Responsible Pharmacist (RP) is crucial in the set-up and maintenance of the medication delivery service

1. Mr Patel was one of your regular patients in The Grange Care Home. Sadly, his health was failing and his doctor anticipated that he would die within the next few days. His GP issued a prescription for end of life medication, including diamorphine ampoules. His prescription was dispensed in the care home dispensary and the delivery was booked with the Company delivery service. When the driver came to collect the items for delivery the diamorphine ampoules were not handed over as they were not retrieved from the CD cupboard.

   Later that evening, the nurse in the care home decided that she needed to inject Mr Patel with diamorphine and she found that the ampoules had not been delivered. Our pharmacy was closed at this time and a new prescription had to be obtained. Mr Patel's daughter spent precious time that she could have spent with her father visiting a late night pharmacy to obtain a supply of diamorphine ampoules so that he did not die in pain.

   This sad incident demonstrates the key role that the pharmacist must play in overseeing the handover of medication to the delivery driver.

2. On another occasion, our driver did not follow the delivery SOP and put the bag of medicines through the patient's letterbox. Inside were two dogs and they consumed most of the medicines, levothyroxine and simvastatin. The dogs were taken to a vet with one dog being on life support and the other under observation. Obviously the dog owners were very upset and the vet bills had to be reimbursed.

3. Mrs Vincent called to say her 92 year old Aunt Vera normally has a blister pack delivered on a Friday but no delivery was made as it was a Bank Holiday (Good Friday). Vera has been without medicines for four days and she is very anxious as she is a cancer patient. Mrs Vincent was told that the medicines were delivered a day late to the pharmacy so too late to make Friday's delivery on Thursday.

Insight 4 – The patient must be able to positively identify himself/herself on every occasion. If not, an alternative solution should be found for reasons of patient safety

1. Your patient, Mrs Edwards, has become increasingly confused over the last few years and she was recently diagnosed with dementia. Her supply of buprenorphine patches and blister pack were delivered to her at home on Wednesday afternoon.

   On Friday morning, the local district nurse phoned the pharmacy to say that Mrs Edwards hadn't got any patches because they hadn't been delivered to her. The pharmacist contacted the delivery service manager and confirmed that the Delivery Sheet and CD Delivery Sheet had been signed by Mrs Edwards. The nurse then made arrangements to obtain another prescription to replace the buprenorphine patches that could not be found but you remain concerned about where the medication could be and feel that she should not be allowed to take receipt of her own medication in future.

2. Deliveries of medicines which had been dispensed into blister packs were made to two vulnerable patients living in the same street. Both are well known to the driver, one of whom was alcoholic and elderly and the other frail and elderly. Unfortunately, the driver mixed up the bags, resulting in the patients receiving the wrong medication. Neither noticed that they were taking the wrong medication for several days.

   This incident shows how important it is to ask patients to identify themselves and confirm their address.

Insight 5 – Hiding medication from the patient is not appropriate from a community pharmacy delivery service

Mrs Rogers took delivery of her blister pack from Charles, the delivery driver. The special instructions for this delivery included putting her pack in "the cupboard above the microwave" but Mrs Rogers would not let Charles into her house and signed for her medication on the doorstep. Later, the pharmacist was informed by Mrs Rogers' carer that she had taken a double dose of gliclazide tablets and was required to have her blood glucose levels checked by a nurse.

This incident demonstrates the problems that can arise if we are asked to hide medicines from patients.

Insight 6 – Safe havens (i.e. a lockable box outside the patient's property) should not be used for the delivery of medication

1. Mrs Old has received her medication from your pharmacy for the past few years and the regular driver, Bob, always left her medication in the porch at the front of her house. He would ring the bell and leave the package and go. Bob has recently retired and the new driver, Alison, has refused to do this. Mrs Old has written to head office to complain, asking how Alison got the job as she didn't understand anything!

2. A home delivery was made to Mr Young. He was contacted by telephone to inform him of the planned delivery of four blister packs, insulin from the fridge and needles. He confirmed that the items could be left in his shopping trolley outside. The pharmacy team have had several problems with this patient and he refuses to answer the door to sign for the delivery of his medication.

   On this occasion, Mr Young did not receive any of his medication although it had been left as requested in his trolley. It seems that someone else, known to the patient, took his medication from the trolley outside his house.

3. The pharmacy delivery driver, James, left medicines on the door step of a residence which houses vulnerable adults who are cared for by an agency. These medicines, which were in blister packs, were then found by an anonymous person who opened up the blister packs and threw all the tablets across the front porch. The mess was discovered later by one of the carers and this was then reported to the pharmacy.

   On investigation, it appears that James put the medicines down while he was at the door so he could write a note to say he had tried to deliver and there had been no answer. He then forgot to pick up the package and take it back to the pharmacy for another delivery later.

It is important that the relevant SOPs are followed in full at all times to make sure that medication is delivered to the correct patient.

Insight 7 – A key safe access system may be used with the correct consent, SOPs and support for delivery drivers

1. Sarah, the delivery driver, delivered medication to Mr Jones who did not return to his house after coming out to take receipt of it. Although the patient has a key safe, he told the driver he would be fine to go back into his house and took his key. A neighbour reported that Mr Jones was nearly knocked over by another vehicle as he was standing in the road.

2. Mr and Mrs Thomas also have a key safe and after Sarah, the driver, delivered the medication she was unable to get the key out of the door to put back into the safe box and so left the key in the door after leaving the property. The following day, the local safeguarding team phoned the pharmacy to say that when the carer arrived at the property the key safe was open and the key was in the front door.

3. Our delivery driver, Mary, had the code to access Mrs Griffiths' key safe to allow her to enter the patient's home. On one occasion, the key safe jammed so Mary rang the doorbell. Mrs Griffiths attempted to get to the door but fell on the way and fractured her hip. Fortunately, she had an alert button around her neck and was able to call for help. Mary finally managed to gain access to the key and sat with Mrs Griffiths until her daughter and the ambulance arrived.

These incidents illustrate the difficulties that can arise when delivering medicines to patients with a key safe. In addition, our drivers are concerned about their vulnerability should anything happen in the patient's home, for example if anything should go missing, particularly on the occasions on which they enter the house and find no one home.

Insight 8 – Delivery to an alternative address (where the driver does not need to get back in the van) is appropriate to improve efficiency and ensure the patient receives his/her medication in a timely manner

Simon, our delivery driver, took medication for Mrs Evans to her address but she was not at home. He delivered it next door, as he had done frequently over a ten year period in accordance with previous authorisation from Mrs Evans. Mrs Jones, who lives next door, is a relative of Mrs Evans and her son had recently moved in to live with her. Mrs Jones' son accepted the medication and signed for it. It appears that he stole several prescription items (28 x temazepam 20mg tablets, 112 x diazepam 5mg tablets and 56 x gabapentin 300mg capsules) and it has since come to light that he has a drug problem. The police have been informed.

Authorisation to deliver to this address was never withdrawn and we were not made aware of this man's alleged drug problem. It is important to establish a named authorised individual at an alternative address at the time of setting up the delivery service.

Insight 9 – The decision to deliver items by taxi must only be made when all the above options have been explored in full and are considered unsuitable.

1. Blister packs were prepared for Mr Hanson but delivery to his home had not been set up with the Company delivery service and arrangements were made for the packs to be delivered by taxi. The taxi driver went to the wrong address and when he could not get an answer spoke to his dispatch who told him to post it through the letterbox. Mr Hanson was supplied with the following week's blister pack so that he did not go without his medication. However, despite the pharmacist going to the house on numerous occasions, he failed to catch anyone at home and has been unable to retrieve the medication.

2. Another incident involving a taxi driver was when the driver was asked to deliver to a large block of flats used as sheltered housing. He didn't buzz the correct flat and handed the bag of medication to a fellow resident who happened to open the door.

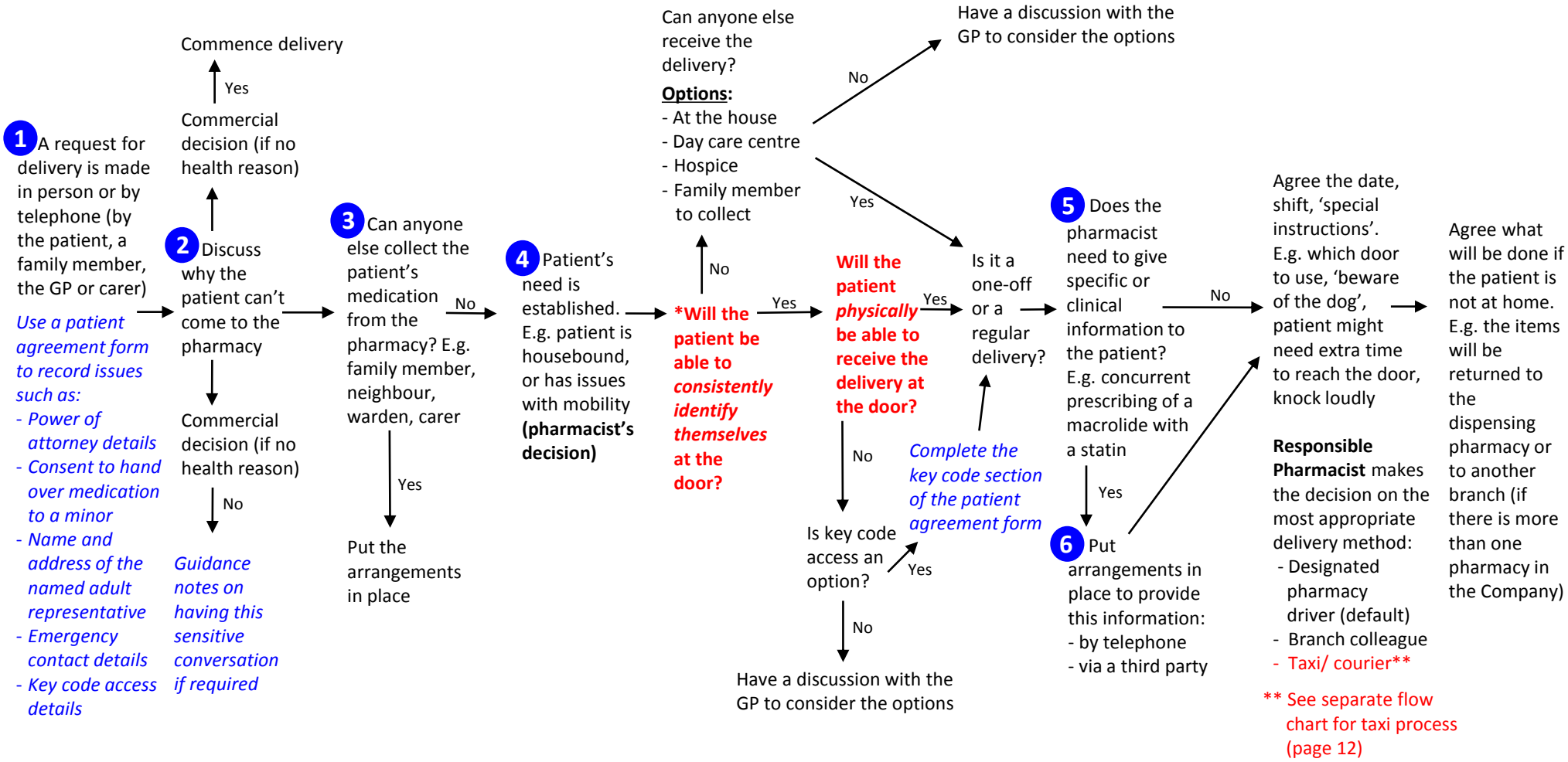
Insight 10 – Sending medication via the Royal Mail (or other courier service) should only be considered as a last resort and, if this route is chosen, the medication should be packaged securely so that the contents are not obvious and the delivery signed for by the intended recipient

1. Hayley, who runs a local catering business, was prescribed medication for oral herpes and she ordered it online, to be delivered to her work address. The medication was sent by Royal Mail and it was delivered by mistake to the hairdressing salon next door, where the package was opened. The owner of the salon brought the package round to Hayley who was really upset. Everyone knows everyone else in town and she was worried that news could spread that she had herpes and that this would affect her business.

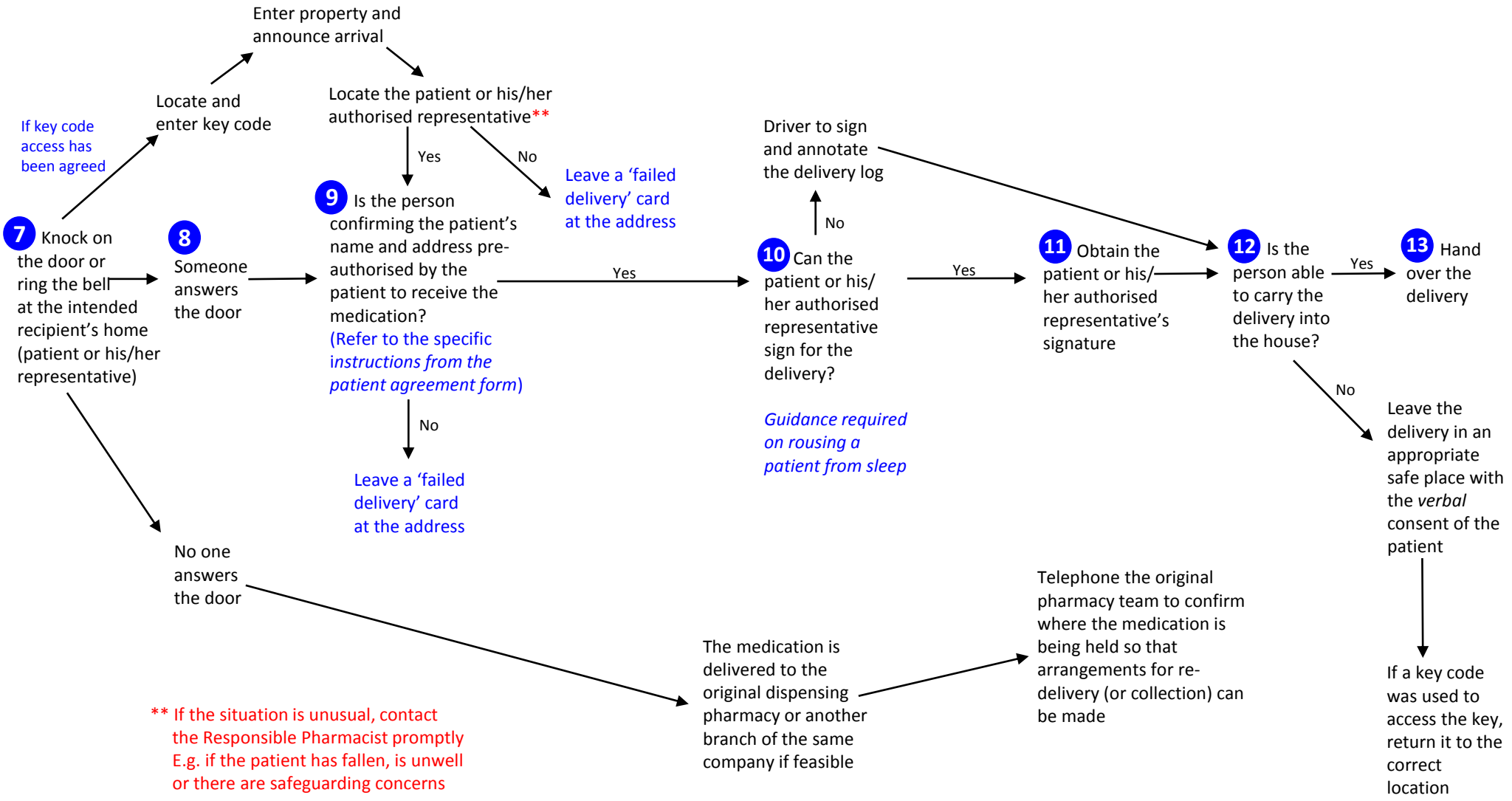
2. Mr King asked for his monthly medication to be sent to him by Royal Mail. Despite paying for the 'Signed For 1st Class' service, Jane, the postwoman, put the package through the letter box. Immediately after she had heard the parcel land on the floor, Jane realised that she had delivered it to the wrong address. However, no one was home so it was not possible to retrieve the package. The Royal Mail followed their delivery incident process, returning to the wrong address on several occasions, but Mr King's neighbour was never at home so they were unable to collect the incorrectly delivered medicines. Mr King's prescriptions had to be dispensed again and the medicines delivered to the correct address. He was very angry about the delay in receiving his medication.

Appendix 2

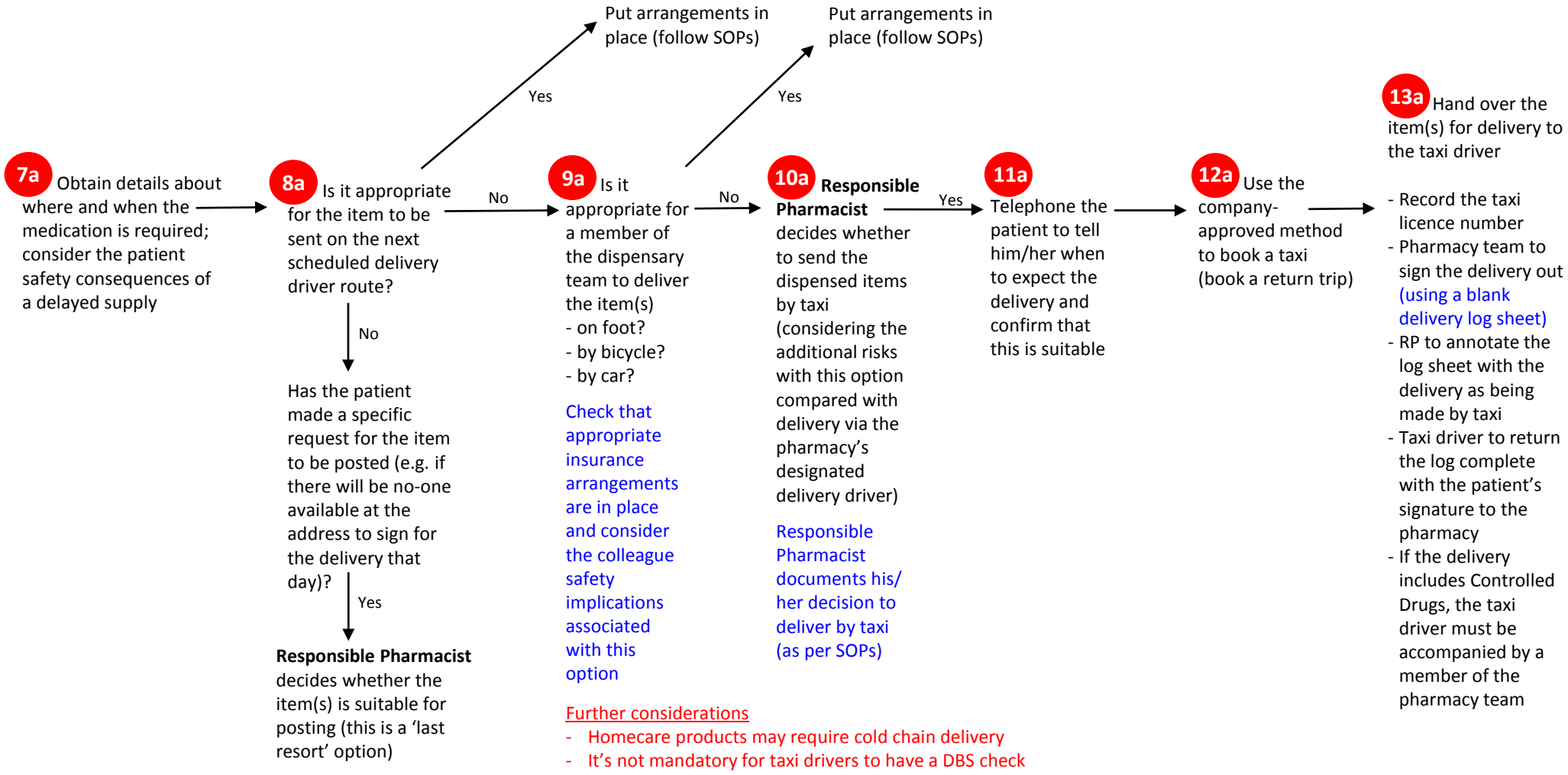
SAFER DELIVERY OF MEDICATION IN COMMUNITY PHARMACY – flowchart process to determine whether delivery is appropriate



SAFER DELIVERY OF MEDICATION IN COMMUNITY PHARMACY – flowchart process for making the delivery of dispensed items



SAFER DELIVERY OF MEDICATION IN COMMUNITY PHARMACY –
flowchart process for making the supply of dispensed items via taxi/courier/post



Further considerations
- Homecare products may require cold chain delivery
- It's not mandatory for taxi drivers to have a DBS check

Online pharmacy: managing patient requests for 'unattended deliveries'

Community pharmacy teams are always striving to meet changing patient needs and customer expectations, especially in the areas of choice and convenience. Increasingly, patients and customers are keen to explore digital solutions for re-ordering their regularly dispensed medication. This has necessitated the Community Pharmacy Patient Safety Group to extend its guidance on safer delivery of medication to cover situations when customers place their orders for medication online and request an unattended (letterbox) delivery of the dispensed item(s). The following guidance is not intended to be exhaustive.

Terms and conditions for posting dispensed medication through the patient's letterbox

During the patient journey through the online ordering service, it is important to set out the **key terms and conditions** that would apply to such a service, together with the potential risks. The patient should be required to agree to the below on **each occasion when an unattended delivery is requested** because his/ her circumstances regarding other persons having access to the premises (and thus the posted medication) are subject to change.

Sample wording

For your convenience, we may be able to post your parcel through your letterbox without the requirement for a signature, depending on the size and type of medication (subject to authorisation by our pharmacist).

We will contact you if this isn't possible. The following terms and conditions are required to proceed with this service. Please tick each of the boxes below to confirm your agreement:

☐ *I confirm my agreement to the posting of my dispensed medication* through the letterbox via the third party delivery service*

** Subject to the dispensed medication being suitable for letterbox delivery*

☐ *I confirm there are no animals and no children who could have access to the posted medication and accept that [state pharmacy name] shall not be liable in the event that another person(s) residing at or visiting the property gains access to the posted medication*

Packaging of items for the unattended delivery service

All medication that is deemed suitable for the unattended delivery service should be supplied in tamper-resistant and tamper-evident packaging. Pharmacy owners/ those in leadership roles with responsibility for the roll out of the service should procure suitable packaging and satisfy themselves as to its fitness for the intended purposes of protecting the medication from damage whilst in transit and breach of patient confidentiality from unauthorised opening of the package after delivery through the letterbox.

Exclusion of some medicines for the unattended delivery service

Medicines are not ordinary items of commerce. Not all medicines are suitable for delivery through the patient's letterbox. The following list is provided for guidance purposes and is not intended to be exhaustive. All patients who have opted for letterbox delivery of an item that is excluded or unsuitable will need to be notified of this.

Examples of medicines for exclusion from the service

- ❖ Items that will not fit through the letterbox by virtue of their size
- ❖ Medicines that require refrigeration
- ❖ Schedule 2, 3 and 4 Controlled Drugs
- ❖ Some Schedule 5 Controlled Drugs (e.g. Oramorph)
- ❖ High risk medicines: anticoagulants, methotrexate, lithium, valproate, all other cytotoxics
- ❖ Other medicines that may be 'desirable' or subject to abuse, such as laxatives
- ❖ Fragile items: glass bottles, vials, ampoules not in original packaging
- ❖ Specials/ expensive lines (for commercial reasons)

The decision as to the suitability of any item for unattended delivery to a particular patient should be made by the Responsible Pharmacist who is in charge at the material time.