GUIDANCE ON THE MANAGEMENT OF CLINICAL WASTE

IN COMMUNITY PHARMACY

The Pharmaceutical Society of Northern Ireland Code of Ethics, June 2009, (Professional Standards and Guidance for the Sale and Supply of medicines, 1.1) states:

"*The pharmacist must ensure that the segregation and appropriate disposal of medicines returned to the pharmacy from a patient's home, a care home or a similar institution must not be supplied to another patient."*

1. Who may return unwanted medicines to community pharmacies for disposal?

- Community pharmacies may receive unwanted medicines from the public. This includes patients, their representatives and representatives of those living in residential care homes. **It does not include residents of nursing homes and their representatives**. (*Appendix 1).*
- GPs and dentists hold contracts with waste disposal companies to dispose of their clinical waste. Community pharmacies are not required to accept waste (out of date medicines or sharps) from either GPs or dentists, except for Controlled Drugs, Schedules 1-3, for supervised destruction, in accordance with DHSSPS guidance. **www.dhsspsni.gov.uk/safer-management-of-controlled-drugs-a-guide-to-good-practice-in-primary-care-version-3-may-2013.pdf**
- Some unwanted medicines from households may be handed to nurses while carrying out home visits, to be returned to the patient's pharmacy. A pharmacist may accept unwanted medicines from households transported by a nurse but is unable to accept the nurse's or other healthcare professional's own stock of medicines.

2. Who may return unwanted sharps for disposal?

- Diabetics regularly return sharps bins for disposal. It is recommended that you remind the patient at the time of dispensing to close the bin securely when filled to avoid needlestick injuries to themselves and to staff when the full bin is returned to the pharmacy (*Appendix 2*).

- Sharps are an integral part of the delivery of some medicines and should be accepted for disposal. There is no requirement to store sharps which were used for cytotoxic and cytostatic medicines in a separate bin from other sharps.

- Those sharps bins collected by Cannon are intended for sharps returned by patients and not for those produced as a result of cholesterol and blood glucose testing in the pharmacy.

- A small number of pharmacies provide a Needle and Syringe Exchange service and will provide a pack containing clean needles and syringes to patients in exchange for used sharps for disposal. Returned sharps are placed into a sharps bin by the patients and should not need to be handled by pharmacy staff.

3. How can pharmacists ensure the safety of staff who accept returned medicines and sharps?

Pharmaceutical bins awaiting collection should be stored safely and in a secure place away from areas of public access within the pharmacy premises.

Pharmacy staff must not be placed at risk by accepting patients' returned medicines and sharps. An SOP should be followed for the disposal of unwanted medicines and sharps, such as that developed by the National Pharmacy Association, ***The Safe and Effective Disposal of Medicines, July 2009*** **www.npa.co.uk.** Staff should read and understand, and sign to confirm that they will comply. The SOP should include protective measures to be adopted by staff when handling clinical waste, such as:

- Do not put your hand into a bag and risk injury from returned sharps.

- Ensure that you are wearing a protective overall if necessary.

4. When disposing of returned medicines, should tablets be removed from their blisters to reduce waste volume?

- Tablet blisters may be removed from the outer box but **do not de-blister**. This significantly reduces the potential for reactions.

- Do not remove liquids from bottles.

5. What is the best way to dispose of a monitored dosage tray (MDS)?

Where an MDS is **disposable**, the tray should be disposed of intact. (Individual compartments may only be opened to extract the contents when these contain controlled drugs, schedules 1-3, which must be denatured before being placed with other waste medicines).

Where the MDS is **reusable**, the individual compartments can be opened for removal and disposal of the unwanted medicines. The pharmacist must ensure that the MDS is suitable for reuse, and precautions must be taken to avoid cross-contamination of medicines.

6. What is the correct way to dispose of patient-returned Controlled Drugs?

Patient returned controlled drugs must be denatured separately before being placed in a container with other waste medicines.

Community pharmacies can accept controlled drugs returned by patients from their own homes for safe destruction and onward disposal even if they did not originally dispense them.

Controlled drugs can be placed into waste containers only after the controlled drug has been rendered irretrievable (i.e. by denaturing).

Wherever practicable, CD denaturing kits should be used to denature controlled drugs. Where this is not possible or practical other

methods of denaturing may be used. Used denaturing kits should be placed in pharmaceutical waste bins that are destined for incineration. Regardless of the methods used, measures should be taken to ensure safety of personnel and non-contamination of the environment, and the disposal of such medicines should be carried out in accordance with guidance issued in Handling and Disposal of Pharmaceutical Clinical Waste (Health Estates 2002).

http://www.dhsspsni.gov.uk/pharmaceuticalwaste-guidance.pdf

If such drugs are stored prior to destruction they should be segregated carefully in the CD safe to minimise the risk of inadvertent supply.
As the quantity of controlled drugs being returned by patients can often pose a storage problem, as well as an increased security risk, pharmacists are encouraged to destroy patient returned controlled drugs as soon as possible.

Details to be recorded in the destruction book should include:

- date of return of the Controlled Drug
- details of the Controlled Drug(s) - name, strength and form, plus the quantity
- role of the person who returned the Controlled Drugs (if this is known)
- name and signature of the person who received the Controlled Drugs
- the patient's name and address (if known)
- the name, position and signature of the person destroying the Controlled Drugs and the same details for the witness
- date of destruction.

Currently, the destruction (denaturing) of controlled drugs can be undertaken in a pharmacy without obtaining a waste management licence as the Environment Agency regards this as low risk activity.

www.dhsspsni.gov.uk/safer-mamagement-of-controlled-drugs-a-guide-to-good-practice-in-primary-care-version-3-may-2013.pdf

7. What is the guidance for disposal of pharmacy stocks of Controlled Drugs which have passed their expiry date?

Any person required by the regulations to keep records of controlled drugs, that is Schedule 1 and 2 drugs, may only destroy them in the presence of a person authorised by the DHSSPS either personally or as a member of a class; this includes pharmaceutical inspectors of the DHSSPS. Particulars of the date of destruction and the quantity destroyed must be entered in the register of controlled drugs and signed by the authorised person in whose presence the drug is destroyed. The authorised person may take a sample of the drug that is to be destroyed.

Date expired or unusable stocks of Schedule 2 controlled drugs should be segregated in the safe until destruction is witnessed by an authorised person. Appropriate records of the destruction must be made.

www.dhsspsni.gov.uk/safer-mamagement-of-controlled-drugs-a-guide-to-good-practice-in-primary-care-version-3-may-2013.pdf

Safer Management of Controlled Drugs (A guide to good practice in primary care, Northern Ireland). Version 3, May 2013.

Appendix 1

Disposal of Pharmaceutical Waste

For a number of years, nursing homes have returned unwanted medicines to pharmacies for disposal.

Following clarification from the Northern Ireland Environment Agency and the Department of Health Social Service and Public Safety, it is apparent that this practice may contravene waste regulations.

The Waste Management Licensing Regulations (Northern Ireland) 2003 details specific requirements for waste management licensing. Those Regulations also make provision for certain activities to be exempted from the requirements of waste management licensing.

One of those exemptions is exemption 39 which permits the temporary storage of waste medicines at a pharmacy which have been returned from households.

The Controlled Waste Regulations (Northern Ireland) 2002 as amended, indicates that waste from a residential home is to be treated as household waste, hence medicines from a residential home can be taken to a pharmacy without the pharmacy requiring a Waste Management Licence.

Nursing homes are not included in the definition of household waste therefore any movement of waste medicines from nursing homes must be taken to licensed or permitted facilities.

Guidance to community pharmacists and nursing homes, October 2011.

Appendix 2

What to do if you receive a sharps injury

If you suffer an injury from a sharp which may be contaminated:

- Encourage the wound to gently bleed, ideally holding it under running water
- Wash the wound using running water and plenty of soap
- Do not scrub the wound whilst you are washing it
- Do not suck the wound
- Dry the wound and cover it with a waterproof plaster or dressing
- Seek urgent medical advice from your nearest Accident and Emergency department , as effective prophylaxis (medicines to help fight infection) are available
- Keep the offending sharp for analysis
- Report the injury to your pharmacist
- Record the incident in your Accident Book in accordance with Health and Safety procedures

Should a sharps injury occur, lessons can be learned and a risk assessment should be performed to reduce the likelihood of further injury.

What is the risk of acquiring a blood - borne virus infection following a needlestick injury?

The principle for any needlestick injury is to assess the risk of blood-borne virus transmission (e.g. HIV, Hepatitis B or Hepatitis C) and then aim to minimise that risk as far as possible.
Systematic assessment of the risk from any incident involves consideration of three categories of information: the circumstances of the exposure, the source of the exposure and the exposed individual.

Circumstances - it is important to establish whether exposure has indeed occurred. Was the skin actually breached by the needle? There is no evidence to suggest that blood-borne viruses can be transmitted across intact skin, or from a needle that has not been used.

Deep injury from a large, hollow bore needle with visible, fresh blood will carry a higher risk than one from a superficial scratch from an old, blunt, solid or subcutaneous small needle through protective clothing. However, it is important to note that the absence of visible blood on a needle should not create a false sense of security.

Source of the exposure - the likely risk of HIV transmission from a needle of unknown source is of the order of no more than 1 in 30,000. This does not justify the risks of post-exposure prophylaxis with anti-retrovirals in most cases. Although HIV is often the greatest fear, in fact hepatitis C and hepatitis B are more common and more transmissible.

The development of antibodies to hepatitis C in serum has been documented following injury from a needle in a hospital waste bag. However, hepatitis C transmission is unlikely in the absence of detectable hepatitis C virus RNA, and similarly many chronically-infected hepatitis B carriers are also of low infectivity.

In the case of definite exposure to blood or other high-risk body fluids known or considered to be at high risk of HIV infection, post-exposure prophylaxis (PEP) should be offered as soon as possible, preferably within one hour of the incident. It may still be worth considering up to 72 hours after the exposure, but the relative benefit of prophylaxis diminishes with time.

The exposed person – the risk of acquiring hepatitis B is reduced if the injured person has been vaccinated against hepatitis B, including booster doses. Dispensary staff and those who may have contact with returned sharps boxes in pharmacies which provide Needle and Syringe Exchange are vaccinated against hepatitis B.

Although no vaccine is yet available for hepatitis C, infection can be controlled with antiviral drugs.

www.nhsemployers.org/Aboutus/Publications/Documents/Needlestick%20injury.pdf

www.advisorybodies.dh.gov.uk or www.dh.gov.uk

HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS (2008), Department of Health.