

Making an impression with MURs

Rubin Moss relays his experience of medicines use reviews and how he conducts them to achieve the greatest benefit for patients



Rubin Moss (right) conducts an MUR with a patient in a consulting room situated within the pharmacy he manages

There is no doubt that the advent of medicine use review (MUR) in community pharmacy has created many new and different opportunities for practising community pharmacists. Until now, dispensing, from what I have observed and experienced, has generally involved preparing the medicine according to the prescription, placing it in a bag, placing a label on the bag (which is usually generated automatically) and giving the bag to a counter assistant to hand out. Thus, there is little or no contact at all between the pharmacist and the customer.

There are pharmacists who do take the trouble and have the time to counsel their clients correctly. MURs present the opportunity for all pharmacists to talk to patients properly, learn more about them and their conditions, and be paid for it. MURs are something of a cross between intensive counselling sessions, as are practised widely in many countries, and the concept of pharmaceutical care as espoused by Hepler and Strand in the US. As far as I am aware, the practice of MUR is a unique concept to this part of the world.

MURs have come with a price tag. Our company has invested large sums of money to

build state-of-the-art consultation rooms which should be adequate for many years to come, perhaps even good enough for the future era of independent prescribing pharmacists. The rooms are large enough to seat three people comfortably and come with all the essential modern trimmings such as appropriate tables on which to work and sufficient space for a computer. Not only are the rooms expensive but large areas of retail floor space have been sacrificed to ensure that the rooms are spacious enough to be comfortable. All our clients have been impressed by the rooms. Sacrificing floor space has meant a loss in retail revenue since we have had to eliminate certain categories of merchandise such as women's tights and hair accessories. Thus, it also becomes essential to maintain retail levels while being able to maximise use of the rooms.

We have used a number of techniques to attract patients to MURs. Our counter staff actively promote MUR by distributing material provided by our company. Where possible, we book appointments in advance. This alone worked well for two to three months, but now I scan the incoming prescriptions and, if I think it appropriate, invite the respective patients into our consultation room. Obviously, to enable me to do this regularly, I need a locum pharmacist to cover dispensing

for at least a few hours. Otherwise, I leave the dispensary staff to dispense and check the completed prescriptions every 15 minutes or so. However, in the case of any urgency, a knock on the door will summon me to check and sign the dispensed items for handing out.

Not every patient is willing to allow me to conduct an MUR. Probably at least 20 to 30 per cent of our clients are suspicious of our intentions and refuse the offer. The most common reasons are that they have been taking their medicines for many years and know exactly what each medicine is being used for, or they may have only recently had a review with their GP and thus need no further reviews.

Once in the consultation area, I always begin by explaining, in some detail, the difference between a GP's clinical review and a pharmacist's concordance review. This appears to settle any nervousness on the client's part and makes them more relaxed. I have been amazed by what I have learnt from customers who appear to be fit and healthy. They have told me about bypasses, strokes and brain tumours, etc — conditions I would not have imagined by merely looking at the prescriptions. I have found that nearly all clients, once relaxed, will readily discuss their conditions and definitely appreciate what information and advice that can be given to them.

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Another technique I have used to good effect is to bring a patient and his or her dispensed items into the consultation area and discuss the medicines one by one. All this takes time and I consider that a decent MUR for a person with more than three medicines should take a minimum of 20 minutes. For those with two medicines, eg, those with hypertension only, a pharmacist should be able to get away with 10 to 15 minutes. To do an MUR properly is time consuming and, for pharmacists like myself who want to keep an eye on all that is happening in the dispensary and at the front counter, it can be slightly frustrating because they will tend to lose track of events taking place in the store. Thus, one has to rely heavily on staff to ensure that everything is functioning well.

What of the MURs themselves?

By far the majority of MURs have been carried out for patients with diabetes, asthma or chronic obstructive pulmonary disease and for those with cardiovascular and gastrointestinal ailments. Except for those patients with asthma, most of the patients have been over 50 years of age. Although it is to be expected, a high percentage of patients with asthma are young. Hypertension and hyperlipidaemia have been the common conditions experienced within the cardiovascular group.

I have been surprised by how little is known about blood pressure. Many patients have no idea about what reading defines normotensive or hypertensive. It is relatively easy to assess their knowledge and, once I realise this is lacking, I always take their blood pressure and spend a little more time explaining the relative readings and the terms "systolic" and "diastolic". Many rely entirely on their doctor's verdict, totally ignorant or not even bothering to know their blood pressure reading. I may be wrong, but I think that anyone with a blood-pressure-related problem should know, each time a GP takes a blood pressure reading, what that reading is. The patient's knowledge can be used as a powerful motivational tool — much the same way as weight is used in any weight reduction programme or by the readings provided by the Smokealyser in our smoking cessation programme. The basic, widely used drugs are reasonably well known by patients and the recent recommendation — not to use a beta-blocker as first line treatment for those with only a blood pressure problem — has caused a little concern.

I spend a little time discussing diet, eg, salt reduction, and regular exercise as non-drug-related methods to reduce or improve blood pressure. The most common side effects that patients have reported have been the cough induced by angiotensin converting enzyme inhibitors and ankle oedema from calcium channel blockers. Some have suffered the ACE-related cough for many months and are relieved to be rid of the problem.

Like with blood pressure, many do not know what their cholesterol levels should be.

I always discuss cholesterol along with diet and exercise.

The main downside of MURs is that the pharmacist has no access to the patient's medical history and biochemical results. This is where the hospital pharmacist enjoys a huge advantage over his community colleagues. This definitely limits the "clinical scope" of an MUR since one has to rely on the patient's knowledge of their history and results and, as I had previously mentioned, in many cases this is almost non-existent. Some patients, especially those on the higher statin dosages, have experienced some degree of myalgia. I have recommended courses of coenzyme Q10 to counter this and this has appeared to be relatively successful.

I have found patients with diabetes to be the one group with a better knowledge of their tests as nearly all self monitor at home. Many know that they are sent to clinics or hospitals for blood tests but are not always familiar with HBA_{1c} results. Again, I could be wrong but I think that GPs should let their patients know their results more readily.

Patients with type 1 diabetes have been changed to glargine and aspartase regimens and the control appears to be considerably better. Diet and exercise are obviously essential aspects to consider and discuss.

The prevalence of asthma is known to be high in the UK and appears to be aggravated by hot weather and the associated incidence of hay fever. With asthma patients, I routinely check their ability to use a metered-dose inhaler and find it somewhat confusing when MDI inhalers are prescribed with breath-actuated, dry-powder inhalers. I always check with the patient to see if the principles of relief and prevention are understood and how often they use the "reliever". I use a peak flow meter to check the patient's peak expiratory flow reading and compare it to the predicted levels on the charts sent to me by Allen & Hanburys. I recommend the use of peak flow meters to anyone who is not stabilised and most GPs have responded by subsequently prescribing them. I also distribute the booklets supplied by Asthma UK as they are really worthwhile.

The COPD patients are always much older and usually ex-heavy smokers. I attended two Centre for Pharmacy Postgraduate Education workshops on respiratory disorders and they were of great benefit. In effect, COPD prescribing is limited and, where there is associated asthma, confusion is sometimes apparent. Because the condition is not reversible, improving the quality of life has to be the main issue.

The treatment for gastrointestinal patients is dominated by the use of proton pump inhibitors. Many of the patients I reviewed did not know what the PPIs were used for, having taken them for months and often many years. Only when I initiated a discussion on their uses did they associate the PPI with their condition. My previous hospital only issued PPIs on endoscopic evidence that met specific criteria and conditions, a policy

which worked well and was cost effective. Can primary care trusts initiate a scheme whereby use of PPIs could be supplied only under certain agreed criteria — even though the recent National Institute of Health and Clinical Excellence guidelines on dyspepsia and gastro-oesophageal reflux disease symptoms sanction the use of PPIs as the first-line empirical choice, largely due to their drop in price?

How are GPs reacting to MURs?

I have discussed MURs with a number of doctors from different practices in my area. Predictably and understandably, the general attitude has been a cautious one, although all realise that it is now a part of the pharmacy contract and has to be accepted. The approach to MURs has varied from practice to practice. I am sure that MURs, in time, will improve the relationship between GP and pharmacy practices. It is probably unrealistic to expect them to read all the MURs sent to them, especially when most do not need any action on behalf of the doctor. When I find something significant, eg, an ACE-related cough, I ask the customer to make a point of showing the MUR to his or her GP. This has worked well and many changes have been initiated by this process.

What of the future?

Surely conducting MURs must become a permanent feature of the community pharmacist's service to the public. Most pharmacists are finding them stimulating and professionally rewarding. I am aware that there are areas of apathy but, hopefully this will only be transitional. I believe one has to be totally comfortable conducting an MUR before the ultimate aim, independent pharmacist prescribing, can be reached. MURs present a big step forward and a major opportunity to improve the esteem and status of the community pharmacist. If this chance is not grasped with both hands, community pharmacists may regret it in the future.

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