

Medication review one year on

Gabrielle Clezy describes what progress has been made and what has been learnt from the medication review service introduced in Surrey over the past year

In the first issue of *Medicines Management* (2002, 1, p8) I described how I had set up a practice-based medication review service in the south of England.

Altogether 37 practices signed up to the medication review programme (out of a total of 38 practices in the PCT area). Information and outcome measures were discussed with stakeholders (practices, pharmacists, etc).

A MIQUEST was written with remote and local enquiries, which are displayed as an EXCEL spreadsheet. This MIQUEST links the patient, age, last review and number of medications that have been prescribed.

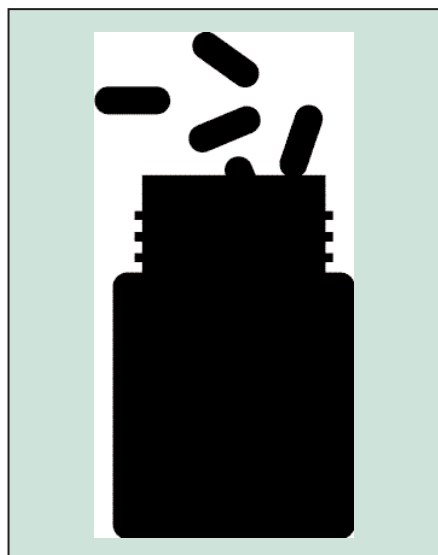
Since the start of the programme we have had numerous enquiries from other primary care organisations and we have been happy to disseminate details of our programme to improve practice nationally.

When the pharmacist posts were advertised, 19 pharmacists were interviewed and seven were selected to become primary care support pharmacists. Training was given to the pharmacists who are self-employed and paid on a sessional basis. In fact, six of them are studying for the Keele University short course in clinical pharmacy for medicine management. The PCT funded this study.

Progress to date

The pharmacists have completed the programme in 20 practices and a further seven practices have a pharmacist currently advising them.

In a small audit of four sessions for each practice, ie 28 sessions, the fol-



lowing results emerged: a total of 233 reviews were conducted (average 8.32 patients per session); 430 interventions were made (average 15 per session or approximately two interventions per patient).

At this stage most reviews have been paper reviews (from medical notes) but a few structured reviews have been done and this area is going to be extended over the coming months (see p10).

Pharmacists initially meet with the lead GP and formulate a working plan. At the end of the 12-session period the pharmacists have provided a written report on their findings and recommendations to the practice and the PCT.

Common interventions

The most frequent interventions include the following:

- * Initiate aspirin/statin (as directed in the National Service Framework for CHD)
- * Eliminating "as directed" dosage
- * Cost saving, eg, 1 x simvastatin 40mg tab instead of 2 x 20mg
- * Identifying patients who need blood or urine tests, eg, insulin-dependent diabetics
- * Detecting poor practice and a lack of medication understanding in practice staff, eg, warfarin monitoring
- * Dealing with compliance issues: synchronising repeats, detecting contraindications and drug interactions.

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Outcome for patients

- * Rationalise medication
- * Synchronise medication
- * Stop medications no longer required
- * Initiate required treatment
- * Decrease side effects and remove ineffective prescribing
- * Improve understanding of medications and increase compliance

Outcome for practice/staff

- * Adhere to incentive scheme
- * Reduce workload for administrative staff
- * Decrease costs by changing to generic medication
- * Decrease costs by reducing stockpiling
- * Adhere to NICE/NSF guidelines by identifying target patients
- * Identifying patients who do not attend clinics and who are not given appropriate medications
- * Multidisciplinary working