

Approaches to medication reviews

Do pharmacists, doctors and nurses take different approaches to medication review? **Clare Bellingham** finds out

Pharmacists, doctors and nurses are different. So it should come as little surprise that each profession has its own approach to medication review. However, identifying these differences and distilling the information to develop best practice can be tricky. Although plenty of research exists on pharmacist-conducted reviews, there is a lack of published evidence on doctor- and nurse-conducted reviews. That is not to say they do not conduct reviews: in fact, the Medicines Partnership's guide to medication review, "Room for review" (see www.medicinespartnership.org), published earlier this year shows that at least as many GPs and nearly as many nurses are involved in medication review as pharmacists. However, the paucity of evidence means that identifying differences comes largely down to the observations of those involved in medication review research.

Observations

Gianpiero Celino, director of Webstar Health (which evaluated "Room for review" for the Medicines Partnership), told *P&M* that if you consider medication review to be everything from checking that repeat medicines are synchronised to intensive face-to-face consultations, then lots of different people are involved in the process. Pharmacists and technicians often carry out technical reviews. "Where there are face-to-face reviews, most of them are carried out by [practice] pharmacists," he said.

The Medicines Partnership is to publish an evaluation of patients' experiences of medication reviews later this summer. According to Geraldine Mynors, head of projects at the Medicines Partnership, community pharmacists are less likely than GPs, or pharmacists employed by GP practices, to conduct face-to-face reviews. She suggested that this might be explained by a lack of time, coupled with a lack of confidence and competence. Alternatively, it could be that pharmacists take a more technical approach to reviews, and put less emphasis on talking to patients.

Mr Celino said that the new GP contract could help to explain the difference in approach. "Regular review of patients' medi-

cines is a quality marker in the new GP contract but it does not define what a medication review is. So while some GPs are doing face-to-face reviews, others are taking a paper-based approach without the patient being present. Both seem to suffice for the purpose of getting the quality points," he said.

Focus

"Pharmacists tend to be able to focus on the medicines rather than the patient, whereas GPs focus on the patient and end up discussing new complaints instead of sticking to the medication review," according to Janet Krska, practice pharmacist, Kirriemuir Health Centre, Angus, who has researched the differences in outcomes achieved by pharmacists, doctors and nurses in medication review. In one study (*IJPP* 2002;10[Suppl]:R86), Dr Krska found that pharmacist- and nurse-conducted reviews resulted in fewer changes to drug therapy and monitoring than reviews conducted by GPs. Why? Dr Krska speculates that this could be a result of GPs having more confidence to make changes. However, she has found that experienced clinical pharmacists are better than GPs at identifying pharmaceutical care issues.

Another difference, pointed out by Ms Mynors, is that GPs tend to be more opportunistic in conducting reviews whereas pharmacists actively look for patients to review. Mr Celino said that in some cases, patients were not aware that the GP had conducted a review. "The review had not provided an opportunity for two-way dialogue," he explained. The reason behind this is the question of whether or not GPs buy into the concept of patients being partners in medicines-taking. "Pharmacists have adopted this message, they know about 'Room for review' but it is a bit more hit and miss with GPs," he said. Knowledge of this document also seems to influence whether or not a reviewer takes a structured approach.

Dr Krska also believes there are differences in how the professions select patients for reviews. She said that pharmacists generally pick elderly patients and those taking multiple medicines, whereas GPs go for an annual

approach and nurses are more likely to review patients who have a specific chronic disease.

Patient perspective

The Medicines Partnership has found a difference in what patients feel comfortable talking about. "Patients expressed a reluctance to bring up what they thought about their medicines with the GP. They were much less inhibited with the pharmacist and felt they could be honest but, on the other hand, thought the pharmacist could not do anything without going back to the GP," said Ms Mynors. Patients also perceived that pharmacists' purpose of reviews was to check up on whether they were taking their medicines.

In addition, Dr Krska has found differences between medication reviews provided by GPs and nurses (*IJPP* 2005;13:77). Before they were trained, GPs tended to conduct reviews using case notes — the patient was not present. They also missed things: an evaluation of 45 reviews identified 79 missed pharmaceutical care issues, most commonly no record of a drug's indication and inappropriate dose or directions. "The GPs were taking a systematic approach but because the patient was not there, they were missing things," she said. "Evidence shows that 70 per cent of issues can be picked up from patients' notes; the remaining 30 per cent will be missed unless the patient is there. How else can you assess compliance and investigate potential side effects," she asked. After training, the average number of missed pharmaceutical care issues decreased from 1.75 per patient to 0.8 per patient. Nurses achieved the same figure — 0.8 missed issues per patient. However, a difference between the types of issues missed was identified. For GPs, the issues most commonly missed were the need for monitoring to be undertaken, no record of the drug's indication, dosage problems and cost-effectiveness issues. Nurses were less able than GPs to identify ineffective or poorly tolerated medicines.

Perhaps the best thing is to forget the differences and remember that the Medicines Partnership found that patients valued having a review, no matter who conducted it.

What PCTs achieve with the Medicines Management Services Collaborative

In this article, **Rachel Farrall** and **Ian Pye**, both assistant programme developers in the medicines management team at the National Prescribing Centre, relate some achievements of primary care trusts through the Medicines Management Services Collaborative

Since 2001, the medicines management team, based at the National Prescribing Centre (NPC) in Liverpool, has helped primary care organisations to improve their medicines management services. Through its Medicines Management Services Collaborative (MMSC), now in its fourth wave, the team has worked with 146 primary care trusts in England, helping develop better medicines management services for up to 27 million people.

Collaborative working

A collaborative approach helps people from different environments to work towards a common goal. The shared MMSC goal is to optimise prescribing, and to improve the patient experience and health outcomes where medicines are involved. This is supported by four detailed aims:

- To identify and address unmet pharmaceutical need
- To help patients get the best from their medicines and so deliver real improvements in health
- To develop innovative approaches to medicines management that have patients' needs uppermost while improving service efficiency and reducing waste
- To provide convenient access to a range of medicines management services in different environments and make better use of the skills of pharmacists

The collaborative provides PCT teams with tools to make improvements. Teams are involved in a co-ordinated programme of events and activities over two years, which include national learning workshops and a bespoke training programme for local project facilitators. Workshops focus on identifying and sharing good practice and giving project teams protected time to develop their own local objectives and agree action plans, based on what they have learnt. Between workshops, teams put their plans into action by testing rapid changes to existing ways of working. Changes are conducted on a small scale and applied more widely if successful. Every month, teams try out their ideas. They study, report and act on data they have collected to measure their improvements. All sites on the programme also develop their own local tools for measuring and assessing progress. Examples of significant improve-

ments that teams have made as part of the collaborative programme are described below.

Specific dosage instructions If a prescription with no dosage instructions is issued, several problems can occur. The absence of clear instructions can cause unnecessary delays for the patient while the prescription is clarified. It might also mean that the patient has to journey between the surgery and pharmacy to sort out the problems, and busy surgery and pharmacy staff have to devote time to resolving problems. Moreover, lack of adequate instructions can mean that the patient does not take a medicine as intended. Through the collaborative, surgeries and pharmacies in St Helens PCT have reduced prescriptions issued with "as directed" instructions from an average of 20 to 0.2 per cent of prescriptions for repeat medicines.

Synchronisation If quantities of repeat medicines are synchronised to run out at the same time it can mean fewer trips to the surgery and pharmacy and, for the surgery, less time spent on processing repeat prescriptions. More importantly, it provides a useful way of monitoring appropriate medicine use. Amber Valley PCT in Derbyshire has introduced prescription synchronisation in its surgeries and has reduced the percentage of unsynchronised prescriptions from 60 per cent to 26 per cent.

Medicines review Polypharmacy increases the probability of drug interactions, can lead to confusion and inappropriate medicine-taking and is a contributory factor to hospital admissions. Regular medication reviews can significantly reduce the likelihood of people experiencing such problems. Blackburn with Darwen PCT has produced a medication review pack for practices. Written for GPs and their staff, nurses and pharmacy staff, it explains why everyone has a role to play in the review process. The pack has been widely promoted through learning days and the PCT's prescribing team has also produced mouse mats with the medication review read

codes and basic questions to ask patients, as an aide-memoire. Through this work, the percentage of medication reviews in the PCT's target group rose from 18 to 79 per cent.

Care home medication reviews

Patients in registered care homes are among those most likely to experience medicines-related problems so regular medication review is useful. The patient population in care homes can fluctuate widely — patients frequently move from one care home to another. Medication reviews for care home residents are promoted through the collaborative programme and local teams collect information on a regular basis to assess progress in this area. A number of PCTs have made significant improvements. For example, East Cambridgeshire and Fenland PCT piloted a multidisciplinary approach involving the GP, community geriatrician, a member of the PCT medicines management team, a care home representative and the district nursing service. In addition to reviewing medication, this team considers the overall care plan for the patient. The pilot has demonstrated improvements in patient care as well as rationalising medication and reducing both medicines-related incidents and costs. Following this success the PCT is extending the scheme to all its homes.

Improvements

As a result of a collaborative approach, improvements are spreading throughout the UK. For example, the concept of regular medication review is now firmly embedded in professional practice. The work on synchronisation of quantities and dosage instructions through the collaborative highlights the benefits of general housekeeping on GP computer systems and also of improved communication between professionals. This has, in turn, helped simplify the medication review process for surgeries — particularly appreciated since the introduction of medication review as part of the new GP contract.

The work being done by the collaborative sites is constantly developing and some sites are starting to look at ways of working with hospital trusts, social services and patient organisations. The NPC team is now also supporting a medicines management programme in hospitals and recently launched a programme to help implement the new community pharmacy contract.

Further details about the National Prescribing Centre team and its collaborative programmes can be found at: www.npc.co.uk/mms

Prescribing in a rheumatology clinic

Mark Thomas, lead clinical pharmacist for ward services at the Queen Elizabeth Hospital, Gateshead, details his experience of setting up a supplementary prescribing rheumatology clinic

In 2003 I took a supplementary prescribing course at Sunderland University. This allowed me to augment my skills in drug and medical history taking and phlebotomy, and to further my experience in prescribing, patient consultation and critical analysis. In March 2004, the opportunity arose to develop a rheumatology supplementary prescribing clinic at my hospital. This was discussed at a number of committees within the trust, and a pilot clinic was established for two months. As a result, we developed a combined pharmacy and physiotherapy rheumatology clinic, which is now almost a year old.

How the clinic works

A consultant rheumatologist reviews the notes of patients referred to the hospital by GPs. There are a number of different clinical pathways into which patients can be directed. One of these is to attend the supplementary prescribing clinic. The clinic accepts patients with mechanical back pain, radicular back pain or neck pain. It runs once a week, concurrently with independent prescribing rheumatology clinics. In our clinic, a supplementary prescribing pharmacist and a clinical specialist physiotherapist work together. We have 15 to 20 new referrals and 11 review appointments each month. Patients are given various questionnaires (eg, EQ5D questionnaire or a Rowland Morris questionnaire) that allow us to gauge their perceived pain and its impact on their quality of life. By analysing these measures at each visit, we can monitor the effect of interventions.

Supplementary prescriber My role as the supplementary prescribing pharmacist is to perform a thorough medication review, to screen for any possible contraindications, to agree a clinical management plan (CMP) with the patient and the clinic consultant, and to prescribe. Most new patients are offered a number of follow-up appointments, at which I review the effectiveness of any pharmaceutical intervention, and either dose titrate existing medicines or introduce new medicines, according to the CMP.

The CMP allows me to prescribe any appropriate medicine, within limits of the British National Formulary, evidenced-based practice and local protocols. The most commonly prescribed medicines include analgesics, amitriptyline, gabapentin and carbamazepine, with adjuvant agents, such as lansoprazole, calcium and bisphosphonates. Amendments to The Misuse of Drugs Regulations 2001 enabled supplementary prescribers in secondary care to prescribe Controlled Drugs from 14 March

2005. Before this, a patient group direction was in place at the trust to allow the supply of codeine phosphate and other weak opiates. This amended legislation has extended the scope of the clinic and gives patients a more diverse range of treatment options.

Clinical specialist physiotherapist The role of the clinical specialist physiotherapist is to assess the patient's symptoms and to support (or oppose) the suspected diagnosis. Our physiotherapist has undertaken several courses on back pain management. She recommends appropriate physiotherapy for the patient and can refer patients for magnetic resonance imaging.

Independent prescriber The clinic consultant acts as the independent prescriber for the CMP and is available to offer advice and guidance.

Communication After the clinic, a letter detailing the findings of the consultation, the pharmacy and physiotherapy treatment plans and follow-up arrangements is sent to the consultant, the GP and the patient. Carbon copies of any prescriptions issued by the clinic are also sent to GPs to keep them informed of any medication changes. The CMP is kept in the patient's medical notes with the patient's letter. At the end of each clinic, there is a short case-conference with the consultant rheumatologist. This provides a useful forum for discussing any difficulties.

Clinic success

We commissioned a user survey to assess the perceived value of the clinic. Questionnaires were given to all patients who attended the clinic between November 2004 and January 2005. Twenty-four patients responded:

- All were "happy to be seen by a physiotherapist/pharmacist team instead of doctor"
- All were "happy to have medicines prescribed by a pharmacist instead of a doctor"
- 78 per cent thought that the supplementary prescribing clinic was "excellent"
- 75 per cent thought that their CMP would have an "extremely positive impact" on their condition

Secondary care provides an ideal environment in which to implement supplementary prescribing and offers excellent outpatient facilities, such as physiotherapy. Running supplementary and independent prescribing



Mark Thomas: supplementary prescribing is a challenging and innovative initiative

clinics concurrently facilitates communication and seamless care and reduces patient waiting times. In addition, the more extensive use of my clinical skills has given me increased professional satisfaction and illustrates how pharmacists can breakdown many of the barriers that exist between medical and allied health disciplines.

Future opportunities

With the success of the clinic comes an increased expectation and demand. I have recently been asked to extend the clinic to offer a pharmacist review slot, enabling the rheumatology team to refer patients with other rheumatic conditions and who require a holistic medication review.

The pharmacy department at Gateshead Health Foundation Trust is progressive and innovative, and has been expeditious in making use of the supplementary prescribing initiative. We now have eight pharmacists qualified as supplementary prescribers, all of whom are actively engaged in establishing a range of supplementary prescribing clinics in areas such as elderly care, diabetes, intermediate care and pharmacy manufacturing. Establishing a large pool of supplementary prescribers will allow all potential clinics to operate smoothly and help to maintain a high level of pharmacist-led patient care.

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Making improvements across an SHA

In this article, **Sarah Alton** and **Steve Morris**, member and chairman, respectively, of the Faculty of Medicines Management, describe the actions taken in South Yorkshire to encourage joint working and to improve medicines management across an entire health community

The Audit Commission's fitness for purpose audits carried out in December 2003 identified prescribing as a key area for improvement within strategic health authorities (SHAs). The report revealed that despite prescribing being a key risk area, there was minimal pharmacy input in many SHAs. Performance management was often limited to prescribing spend. In addition support from primary care trust prescribing teams was limited and it was difficult to tackle prescribing issues (such as the use of expensive, new drugs that affect the whole health community) in a cost-effective, equitable manner.

The challenge

South Yorkshire Strategic Health Authority was formed in 2002 to serve the 1.32 million inhabitants of Barnsley, Doncaster, Rotherham and Sheffield. It covers nine PCTs, four hospital trusts and two care trusts and encompasses an area that, as a whole, is one of the most deprived parts of the UK. The challenge was to promote a region-wide approach to medicines management at a time when the focus of PCTs was very much confined to local needs. The only way to do this was to adopt a facilitative approach to encourage organisations to work together on a common agenda.

Establishing a forum One of us (SA), formerly head of medicines management at a PCT within the region, was appointed the SHA's prescribing adviser. The post is part-time (two and a half days per week) and started with pretty much a blank canvas. Without a team to help implement recommendations the only way to progress was to rely on the full co-operation of all the trusts and their medicines management teams.

A prescribing leads group, which had previously existed but had failed to provide any substantial outcomes or agreements, was re-established. The aim of the group was to facilitate a uniform approach to the development and implementation of prescribing policies across South Yorkshire. Each PCT, hospital trust and community area prescribing committee was represented on the group. Critical to the effectiveness of the group was to maintain a clear focus, high status and the commitment of all the members to drive the agenda. To ensure this, group practice was to report to the PCT chief executives forum. The group is also co-chaired by a PCT chief executive and the director of public health and clinical engagement at the SHA. The role of the SHA prescribing adviser is to co-ordinate group activity using a facilitative

approach (see Panel 1), to share best practice and to encourage collaboration.

The prescribing leads group sets the agenda so that its actions are "owned" by the members and the organisations they represent. Each organisation still has flexibility to prioritise and pursue its own agenda, while working alongside the wider group.

Medicines management framework

The group's first step was to develop a framework for medicines management that each organisation would sign up to. This consisted of the following four elements:

- An annual self assessment of prescribing and medicines management
- Action on key therapeutic areas
- Improved procurement of medicines
- Joint working of area prescribing committees

Self assessment The group developed a self-assessment questionnaire to allow PCTs to review the processes and systems they have in place to optimise medicines management and to identify any areas requiring further action. This tool complements others, such as those produced by the National Primary and Care Trust Development Programme.

Action on key therapeutic areas The group identified a number of key therapeutic areas for action (see Panel 2), including optimising generic prescribing. The next step was to agree the most effective approach to take to tackle these. The group agreed to produce recommendations for each area in the form of prescribing statements and each organisation is responsible for the prioritisation and implementation of these statements as appropriate.

The SHA provides support by funding printing costs and local meetings, and supplying literature. Although these drug areas and messages are not necessarily new, for the first time all PCTs and hospitals across the region are working together towards the same goals.

Improved procurement A number of areas where improved procurement through a common approach across South Yorkshire could result in significant savings were identified (eg, oral nutrition, stoma care, *Helicobacter pylori* test kits and nicotine replacement therapy). We are working alongside the South Yorkshire Supply Management Confederation to take this work forward.

Prescribing committees A major piece of work being tackled by the prescribing leads

Panel 1: Examples of facilitating group activity

- Ensuring sign up to an agreed work programme and collaborative framework
- Sharing best practice through specific guidelines and protocols
- Sharing workload
- Establishing specific workgroups

group is to review the "traffic light" prescribing lists across the region with the aim of producing a single agreed list. This involves co-operation between area prescribing committees. The prescribing leads group has provided an excellent forum for this.

The future

Advantages to working together in this way include:

- The opportunity to share best practice and learn from each other
- Consistency in clinical practice which, it is hoped, will lead to improved patient care
- Greater negotiating power as a group

The project is still in its early stages and there is a long way to go before it meets its aims but, so far, the results are encouraging and the prescribing leads group seems to be working well. Many challenges lie ahead, and it will be interesting to see how the relationship between the SHA, foundation trusts and PCTs develops.

It is hoped that despite any forthcoming organisational changes, a community approach can continue. There is potential for real value to be added to medicines management across the region and thus make a difference for patients.

Panel 2: Areas identified for action

Appropriate prescribing (ie, following national guidelines) need to be achieved for:

- Ulcer healing drugs
- Nitrates
- Lipid lowering drugs
- Clopidogrel
- Aspirin (enteric coated)
- Non-steroidal anti-inflammatory drugs
- COX II inhibitors
- Inhaled corticosteroids
- Glucose testing strips