

Self-medication — take it or leave it

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Self-medication (or self-administration of medicines) for patients in hospital has once again been highlighted as a key issue for implementation in the NHS. The Health Care Commission (HCC) has included self-medication as an indicator within the “medicines management” section of the “acute hospital portfolio”. In addition, the National Service Framework for Older People, a 10-year plan that started in 2001, included a medicines management milestone, for achievement by April 2002, requiring hospitals to implement self-administration of medicines for older patients to support optimal medicines use by older people.

Self-medication for hospital patients is not a new concept. A number of small studies in the 1970s and 1980s explored the benefits of such schemes, although there was no standard definition of self-medication. Currently, neither the NSF nor the HCC acute hospital portfolio define self-medication, leaving local trusts to create their own definition. These usually include reference to the desire to promote complete or staged patient autonomy in medication taking for hospital patients.

Is self-medication by patients an ideal to aspire to for all patients in hospital? The evidence for this is poor. A recent critical review of the self-medication literature on patient compliance, medication knowledge, satisfaction, treatment failures and medication-related admissions suggested that most of the 51 studies included were poorly designed and had methodological flaws. Another proposed benefit of self-medication in hospital is that it promotes and maintains patient independence and autonomy, in the hope that patients are discharged from hospital with sufficient knowledge to take their medicines correctly and safely. In this way, readmissions due to non-compliance with medication (highlighted as a problem in the NSF) or medication errors may be reduced. However there is no evidence to support this. In addition, there are no long-term studies demonstrating an improvement in concordance following discharge, or any evidence directly linking self-medication with reduced readmission rates.

For self-medication schemes to be safe and effective, patients must be carefully selected. Patients require adequate manual dexterity and cognitive function and the ability to demonstrate sufficient knowledge of their

regimen to remain in control of their own medication during their inpatient stay. It is important to target patients taking an established regimen, rather than a rapidly changing prescription, and those who will be responsible for their own medicine-taking once they leave hospital.

Nevertheless, hospitals are now mandated to attempt to introduce self-medication schemes again. The current system for hospital inpatients in the NHS does not routinely assess a patient's ability to comply with prescribed regimens. Consequently, patients may be discharged with little knowledge of their drug therapy or without identification and resolution of practical barriers after discharge, such as difficulty with blister packs. Therefore, in response to the national directives, self-medication schemes have been tested in a number of hospitals around the UK that have produced detailed self-medication policies to support implementation. However, the most recent

HCC report indicates that most hospitals have not fully implemented this NSF 2002 milestone and, anecdotally, it seems that few hospitals that have started this initiative have been able to maintain it in the long term for most of their wards. Our local experience provides some insight as to why this might be.

At Northwick Park Hospital, we set up a self-medication scheme for older people, supported by a hospital self-medication policy. Patients were assessed by the medical team for suitability for entry into the self-medication pilot scheme, using criteria expanded from Trewin and Veitch's original criteria in 1987 and, where appropriate, the self-administration of medicines scheme was explained to the patient and the process was agreed with the patient. Nurses or pharmacists completed the patient assessment and a staged self-medication programme was started. Patients would first take their medicines from their bedside lockable cabinet with the help of nursing staff. Once confident and competent to take their own medicines, they were given custody of the locker key. Patients' progress with self-medication, including compliance issues and education needs, were addressed at every ward round during their inpatient stay and recorded by the nurse.

Several issues were highlighted as a result of the pilot study. Few patients were able to

self-medicate in hospital. For the older patients studied, some could not be offered self-medication because of their physical or cognitive state, and a number would not assume responsibility for medication on discharge anyway. Many were too unwell during their admission and, once well enough to self-medicate, were rapidly discharged. A number of patients were unable to self-medicate because their medication or medical condition changed rapidly.

This was reflected in the results, which showed that only two patients on a ward of 30 patients over a six-week period were able to self-medicate. In addition, nursing staff expressed concerns about the risk of overdose and drug errors among self-medicating patients where their cognitive function was changing. Concerns were also expressed about the time required to train nursing staff and patients to facilitate safe self-administration as well as the nursing time required to supervise and assess patients taking their own medicines.

In practice, self-medication schemes are labour- and time-intensive exercises that have the potential to increase anxiety among nurses, doctors, pharmacists and patients. Self-medication in hospital cannot emulate the patients' home scenario due to legal and clinical governance limitations that apply in hospitals, such as the storage of Controlled Drugs and the requirements for keeping all medicines in a locked cupboard. There are also inherent medico-legal issues that need to be addressed with the potential risk of increasing the number of drug errors, eg patients taking the wrong dose.

Self-medication for hospital patients is something that we should aspire to provide. However, in an acute hospital, with pressure to reduce length of stay, it seems impractical to implement a scheme which by its nature requires time for the patient to benefit. Criteria for inclusion must focus on stable patients who are to remain in hospital for a number of days before discharge to allow appropriate self-medication assessment and trial. Most patients will have an average hospital inpatient stay shorter than that required for a successful self-medication scheme to operate.

It seems prudent to target self-medication as an intervention for longer-stay care (eg, intermediate care, where patients may be discharged home). Use in long-term care has been shown to be effective. In the meantime, there is no substitute for good communication between primary and secondary care to ensure that medication-related discharge planning occurs well in advance of discharge and is followed up from hospital to community and vice versa.

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