

Monitored dosage systems are not the only solution for older people

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I read with interest the reports and discussions about monitored dosage systems in *The Journal* and cannot help thinking how we seem to be regressing instead of progressing. Whether or not to fund MDSs and who should fund them are contentious issues that remain unresolved in many primary care organisations, trusts and social care organisations. But this is a convenient distraction from the real issue: the lack of a clear and joined-up system across health and social care to support people who need help taking medicines. Short-term solutions that focus on implementing in-house policies (or otherwise) that have not taken into account the impact on other organisations only add to the problem, with patients caught in the middle when they move across care settings.

Older people are probably the greatest users of medicines and MDSs. Providing an MDS, however, is only one way to help people take medicines. There is no reason (aside from historical use) why this method should be chosen in preference to others, particularly as MDS use is fraught with many problems. Lambeth Primary Care Trust's drug error incident reporting system shows that a high proportion of incidents are related to the use of MDSs. In addition, a number of disputes between community pharmacists and other practitioners relate to MDSs.

Other options

In spite of their widespread use and associated costs there is little evidence to validate the benefits of MDSs. And, given the current financial pressures and the burden of adverse drug events on the NHS, can we continue to justify their inappropriate use? Many other interventions can support medication. For example, pharmacists can initiate a collection, delivery or repeat dispensing service; and supply winged tops, large bottles, compliance aids (eg, Haleraid), tablet cutters, reminder charts or alarms. Similarly, prescribers can change formulations, dosage times or frequency, and prescribe medicines with fewer side effects to improve compliance. Sadly, the uptake of medicines use reviews, which are fully funded, patient centred and a key tool to facilitate concordance, remains low.

Home care workers can prompt or assist the taking of, and administer, medicines. Relatives and friends are an untapped but useful resource. Older people sometimes devise their own routines for taking medicines and, in some cases, the only intervention required may be to work with them to reduce any risks.

I suggest two main reasons for the inappropriate use of MDSs. First, a poor understanding of, and a fragmented approach to tackling, the wider factors that affect medicines use in older people. Even within pharmacy, the barriers to delivering effective support across care settings are not fully appreciated (eg, large font labels given in hospitals may not be a practical option in the community unless they can be reproduced).

Supporting older people to take medicines is everybody's business. However, pharmacists have a key role as medicines experts and should be driving improvements, providing information and support to older people and their carers. To do this we must give consistent advice based on the law, robust evidence or available best practice.

Although grey areas exist, the Medicines Act is quite clear and should be our starting point. Instead, pharmacists are pressured by social services and care home managers, etc, to provide MDSs even when there is no apparent benefit. The Disability Discrimination Act is often misquoted as the means to secure MDSs from community pharmacy. In care homes, MDSs are used for staff convenience or as a poor substitute for adequate training. There is no justification for this or the associated drug wastage when most patients do not self-administer medicines.

I have seen drugs like alendronate dispensed in MDSs with no consideration for the fact patients can have difficulty identifying the tablet from several in a compartment and, therefore, may not take it as instructed. I have seen many older people taking medicines in ways that do not reflect the prescriber's intentions; medicines inadvertently littered in MDS compartments as patients struggle to manipulate the device, and medicines to be taken before and after food placed in the same compartments. Confusion from an inability to identify individual tablets in the device can also hinder decision-making about what to take. Often, *prn* medicines (and liquids and inhalers etc) cannot be dispensed in MDSs. Such situations can lead to further confusion and defeat the original aim of using MDSs to simplify drug regimens. Other problems can arise from drug instability, the complexities of the repeat prescribing and dispensing process, drug changes and wastage.

The question we need to ask is: are we leading medicines management improvement or being led down a risky path? Our position should be that standard labelled containers remain the main way to dispense medicines, and deviation should only follow a docu-

mented assessment showing that the benefits outweigh the risks for the individual.

Second, there is no shared vision across organisations around what is needed to support older people with medicines and how to provide this support. For frontline staff, the absence of a clear pathway and guidance on practical solutions for those who need help is why most settle for MDSs as a "one size fits it all" solution. A care pathway is about how people work together and communicate with each other around the needs of the patient. An integrated medicines management pathway will allow whoever identifies or assesses a medicines need, as part of routine care, to offer practical help or refer to the most appropriate individual with the skills required to meet the need.

Mapping the current pathway and determining existing resources and interventions should be the starting point to identify gaps and ensure the best use of resources. Where specific devices or support over and above these are required, health and local authority funding streams (eg, primary care contracts, practice-based commissioning) should be sought to develop local services. For older people with complex needs the expertise of pharmacist prescribers, pharmacists with special interests, consultant pharmacists and case managers can be used.

Solutions

Moving forward, the priority is for all provider and commissioning organisations to agree a pathway that will improve the older person's journey across care settings. It should include the identification and assessment of medicines management needs (within the context of wider health and social care circumstances), planning with the individual how needs will be met, and then delivering and monitoring these services. Part of this process will involve reviewing existing care and capacity then redesigning services around the patient rather than professions or organisations. Pharmacists are well placed to lead and drive this process.

The advantages of a whole systems approach include better understanding of the issues across the board, provision of a variety of services by a spectrum of individuals, teams and organisations to match the patient's need, better access to support, more capacity and sustainability in the local economy. I am optimistic that such an approach will reduce the current problems with MDSs and ensure their use only in those who would truly benefit from them.