

Improving medicines management in intermediate care and social services

Two pharmacists in Leeds are working as intermediate care pharmacists. One of them, Claire Standage, told **Clare Bellingham** about how they are tackling medicines-related problems, how their roles are developing and what the future holds

In 2003, the intermediate care team in East Leeds told East Leeds Primary Care Trust that it was spending too much time sorting out patients' medicines. Focus group work with social services showed similar problems. So the PCT, the intermediate care team and social services got together and created a one-year project to tackle the problem.

The overall aim of the project is to improve medicines management services for older people in Leeds. It has two strands: tackling issues in intermediate care and also in social services. Two part-time pharmacists have been employed to run the project: Claire Standage and Gillian Hunter. Together, their roles equate to one-and-two-thirds times a full-time position.

Intermediate care team

The intermediate care team comprises nurses, occupational therapists, a physiotherapist and clinical support workers.

Altogether, the team has about 45 patients on its books at any one time. Roughly 70 per cent of the patients are referred to the team on discharge from hospital. The problems that patients face on discharge are well-documented — patients cannot cope with new medicines at homes, they do not know what to do with large stocks of old medicines at home and repeat prescription records at surgeries do not tally with the new medicines — so it is clear why they need the help of the intermediate care team. But the team tackles a lot more than medicines; it takes a holistic approach to rehabilitating a patient after a stay in hospital.

The remaining 30 per cent of the team's workload are patients referred from community practitioners such as GPs and district nurses. "They tend to be people who have had a fall or a stroke and need a short burst of rehabilitation intervention until they become stable enough to continue on their own," Miss Standage explains.

"Intermediate care is an ideal place for pharmacists to work," she says. "Every time I go to see a patient I make some sort of intervention, even if it is something relatively basic such as ordering easy-open container tops."

Needs assessment

When a patient is first referred to the intermediate care team, a member of the team visits the patient at home and carries out a needs assessment. As part of this assessment, a standardised form has been introduced to identify problems with medicines. This first, basic

medication review is then given to the pharmacists who use it to prioritise the order in which they will visit patients for a more in-depth look at their medicines.

The basic review covers practical issues around supply and administration of medicines, including how repeat medicines are obtained and whether the patient needs help to take their medicines. "One of the biggest problems is that medicines are about to run out and patients don't know how to deal with repeat prescriptions, particularly when their medicines have been changed. So we will see these patients before their current supply runs out," explains Miss Standage.

Once patients have been prioritised, one of the pharmacists then carries out a more detailed medication review. A first visit takes between 45 and 60 minutes per patient. Shorter follow-up visits are also carried out. "In the review, we try to get a picture of the patient's daily routine and how medicines fit into it," explains Miss Standage. "It has been designed so we don't duplicate the questions asked in the first assessment."

Again, the review is based on a structured questionnaire. It begins by listing all the medicines the patient takes, including over-the-counter and herbal preparations. It also lists any medicines on the patient's repeat prescription list that are currently not being taken and the reason for not being taken. It then goes on to cover the questions listed in Panel 1.

On average, the pharmacists review 35 patients a month. "Our role is to make a judgement on how the patient will manage with their medicines and work out what help they need to improve the situation. We try to take a concordant approach whenever possible."

There is nothing new about the interventions the pharmacists make: they are common sense. Examples include rationalising medicines so patients take the fewest number of doses possible, recommending easy-opening container tops, putting reminder stickers on

Pharmacists Claire Standage (left) and Gillian Hunter

the refrigerator or cooker, suggesting the patient keeps their tablets beside their bed and involving the family in prompting medicine-taking. They also tackle issues like hoarding medicines and might make referrals to home carers or social services if appropriate. "The majority of problems I identify are with adherence to the regimen," she comments.

Some interventions are less obvious. For example, home carers tend to visit only in the mornings or early afternoons. If patients rely on home carers to help them take their medicine then those medicines prescribed at night simply will not be taken. "So whenever possible we switch evening doses to the morning, even for things like statins. In an ideal world we wouldn't have to do this but it is better for them to be taken in the mornings than not at all."

Another example is with compliance aids. "If patients are given something separately to their compliance aid, they may not take it. So we work with the community pharmacists to put everything into the aid," Miss Standage says. "You have to take a flexible approach. We would never compromise a clinical decision but you have to be practical and consider how a patient is taking their medicines."

Her experience of reviewing patients' medicines at their homes makes Miss

Standage think that it is the optimal place for reviews to take place. "It is only there that you get a real feel for how they cope with their medicines. You can understand their daily routine and work out what help they need. If the home is in complete chaos, they are probably not taking their medicines properly."

Following the review, the pharmacists speak to the GPs to discuss interventions and update the patients' repeat prescription record. The GPs will make changes to prescriptions when needed.

One of the problems often encountered with the repeat prescription systems at the GP surgeries is that no one person takes responsibility for ensuring that repeat records are updated, she explains. This can lead to a long list of medicines on the repeat, many of which should no longer be taken, so it is easy for the wrong ones to be prescribed. "There is a potential role for pharmacists to help solve this, working across a number of GP surgeries."

Miss Standage also involves community pharmacists. "After a review, I often go to see the patient's community pharmacist to explain what I have done and to ask for their help with certain things, for example ensuring the patient receives large-print labels," she says. "Sometimes I feel like I am treading on community pharmacists' toes. After all, they are the ones who have known the patient for years. The only reason it is me doing the reviews and not them is because I have got the time to carry out home visits."

She adds that the majority of community pharmacists would like to get involved in this type of work but that the current pharmacy contract is holding them back. She has high hopes that the new contract will solve this. "For instance, if a GP prescribes an evening dose for a patient who we have changed to having all their medicines in the morning, the community pharmacist should be flagging this up to the GP."

Panel 1: Review questions

After taking a full medication history, the questions asked during the medication review are:

- Do you ever have problems obtaining your medicines or ordering repeat prescriptions?
- Does anyone help you with your medicines at home? If so, who and what do they do to help?
- Some people forget to take their medicines from time to time. Do you? What do you do to help remember?
- Some people take more or less of their medicines, depending on how they feel. How often does that happen to you?
- Most medicines have side effects. Do you have any?
- Do you have problems getting medicines out of boxes and bottles?
- Do you have problems reading your medicine labels?
- Any other problems?

The two intermediate care pharmacists then review the patients after three months. The follow-up visits are an essential part of the service. "I feel strongly that teaching someone about how to manage their medicines is an ongoing process. We can't just visit someone once and expect everything to be perfect after that. It can be a steep learning curve at first," Miss Standage comments.

Social services

The second part of the one-year project involves social services. Once the medication reviews in intermediate care had been established Miss Standage, while still undertaking some of the reviews, started to tackle medicines management in social services and look at strategic issues. The bulk of the reviews in intermediate care are now carried out by Ms Hunter.

"I started by shadowing social service home care employees to find out how they deal with medicines," explains Miss Standage. "Before, I thought that they just prompted the patient to take their medicines but it is actually much more hands-on than that. For example, they pop the tablets out of blister packs for patients."

It is also social services staff who are carrying out the Single Assessment Process (SAP) in Leeds. "If medicines problems are identified, the assessors simply do not know how to deal with them or who to refer problems to," Miss Standage explains. "So often, their only way of helping is to organise a compliance aid and home help staff to prompt the patient." This takes the responsibility away from patients. "Compliance aids should be a last resort. They take patients' independence away so patients don't know what their medicines are any more. Before introducing one, bigger-print labels, medicines charts and prompting by family and home care staff should all be tried," she comments.

This demonstrated exactly how much a pharmacist's input was needed in the SAP. "In an ideal world, the SAP assessor could contact the community pharmacist for advice about how to deal with medicine-related problems but, at the moment, they are referring patients to me." She adds that being this point of reference is something that all pharmacists could consider.

Another problem is that medicines fit into every aspect of a patient's care. "The GP prescribes, the community pharmacist dispenses, the district nurse and social services assist. . . no one has sole responsibility and everyone assumes it is someone else's job. This is why, quite often, things go wrong," Miss Standage says.

Having studied the local situation, Miss Standage reported her findings to the East Leeds area home care manager and the resource manager of the community support service at social services. "This is where it gets really exciting," she says. "I presented the results at a meeting of the group responsible for implementing the medicines section of the National Service Framework for Older People in Leeds." Some of the issues she highlighted are listed in Panel 2.

Panel 2: Current problems

Some of the issues highlighted as being wrong with the current system of medicines supply are:

- The current social services medicines administration system is not used consistently and documentation is variable
- Problems with compliance aids
- There is no standard way of handling medicines by home care staff
- Many different agencies are involved with medicines but there is no awareness of roles and responsibilities
- Hoarding of medicines, particularly laxatives and analgesics
- The large incidence of non-compliance with medication

At the meeting, it was decided that a medication policy subgroup should be established. Where this new group is different is that its members include sheltered housing wardens and independent care home staff, along with GPs, community pharmacists, district nurses, social services and home carers. "The group aims to improve medicines management for older people," she says. "We will be writing a medication administration policy that we want all the professions to sign up to. It will clearly describe the roles and responsibilities of all those involved." The work is already progressing: the group held its first meeting last week.

The project's future

The project is allowing data to be collected on whether a pharmacist is needed in the intermediate care team. For the role to be funded beyond the project year, its use has to be demonstrated. Miss Standage is convinced that it will carry on, but perhaps based in primary care rather than within the intermediate care team.

With the work that the medication policy group is carrying out, everyone in health and social services will be involved in medicines management in Leeds in the future. "A medication review can only give you a snapshot of the patient's life. Sometimes a patient can be quite lucid and you decide that everything is fine, only to be told by the home carer that the patient has dementia and will have forgotten everything you have said an hour later. So it is crucial that everyone is involved to achieve a sustainable intervention," she says.

Sustaining the intervention is what it is all about. "Medicines regimens are fragile and need to be protected. They can be stable and working fine and then something happens, like a GP prescribes a new drug at a different time, and suddenly the whole regimen is blown apart," Miss Standage says.

Pharmacists are a key element of keeping the fragile structure sealed together by providing an ongoing medicines management service.