Sorting out the muddle in systems used to support medicines adherence

Formal configuration of services together with use of standardised tools is a leap towards intelligent implementation of the national medicines adherence guidance

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UK literature suggests that between 33 and 50 per cent of medicines for long-term conditions are not taken as prescribed.¹

One popular policy to support patients with compliance/adherence issues has been to dispense their medicines in multicompartment aids (MCAs). However, there has been increasing awareness that this one-size-fits-all approach is frequently inadequate as a medicines compliance/adherence solution.

More recently, the National Institute for Health and Clinical Excellence issued clinical guideline 76, “Medicines adherence”.² The guideline recognises two broad categories of non-adherence: the “can’t takes” (non-intentional non-adherence) and the “won’t takes” (intentional non-adherence) — although the two are not mutually exclusive. NICE provides a useful framework for the delivery of a personalised medicines adherence service but it does not provide the tools to operationalise the guidance.

Developing a solution

Fact finding

In order to explore service improvement we first built a complete picture of current service provision from both the service provider and the patient perspectives (process mapping). Starting in August 2007 we worked collaboratively with health and social care professionals and patients, conducting domiciliary patient reviews of MCA use, a series of one-to-one practitioner interviews, and local stakeholder events to gain an understanding of what was happening to support medicines use locally.

We also conducted a rapid literature review and spoke to primary care trusts to find out how medicines adherence service developments were progressing further afield.

Figure 1: A visual representation of the integrated local medicines pathway developed to deliver personalised solutions to improve patients’ medicines use (reproduced with permission, Pharmaceutical Resource Network Ltd)
Learning
We found that some patients had difficulties using their mCAs, others were non-adherent despite having an MCA, and none had been offered an alternative to an MCA.

At a local level, we found that doctors, nurses, pharmacists and social care professionals (SCPs) have limited awareness of the different services provided by each other to support patients with taking medicines. Relatively few nurses and SCPs know about medicines use reviews, repeat dispensing or practical solutions to improve medicines taking other than mCAs, nor do they understand how their patients could benefit from and access these interventions.

We also highlighted a plethora of medicines adherence assessment tools being used in different settings with limited transfer of assessment data across sectors. For example, SCPs routinely ask questions about use of medicines in their single assessment process, but there is no formal local pathway to guide referral of patients with problems. In contrast, the national MUR service does not require the use of any formal tool, but it is recognised that there is considerable variation in practice with the delivery of this service too.

Finding a way forward
At a well attended, cross sector stakeholder event including patients, practitioners and commissioners, we presented our findings and discussed the issues and potential solutions. We employed the nominal group technique to rank specific service improvement initiatives in order of priority for implementation.

Stakeholders overwhelmingly agreed on two priorities that when put together called for the development and implementation of an integrated local medicines pathway with standardised tools to screen for and to assess medicines adherence issues.

Local solution
Figure 1 is a visual representation of the integrated local medicines pathway developed to deliver personalised solutions to improve patients’ medicines use. Of particular relevance is that there is little that is new in the pathway in the way of service provision, much of it is already happening, albeit in a fragmented way. The pathway represents formal configuration of existing services and has facilitated identification of areas where investment is required, either to fill service gaps or to integrate working practice.

Standardised tools to support medicines screening and patient assessment have been developed collaboratively with local stakeholders. These tools are based on the principles of medicines adherence theory and on the availability of local medicines support solutions. They also reflect the principles outlined within the NICE guidance and have been refined following small pilots to support their pragmatic use across a range of settings.

Although there is still much to do to improve patient adherence locally, formal configuration of services together with use of standardised pragmatic tools is a leap towards intelligent implementation of the national medicines adherence guidance. In addition, it facilitates joined-up collaborative working across health and social care interfaces.

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References