

Implementation of a Medicines Adherence Support Service for Older People in NHSCT and SEHSCT Areas in Northern Ireland

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Introduction

Non-adherence to medication has been reported to be as high as 50%. This leads to a reduction in expected clinical outcomes of therapy, a higher risk of avoidable medication related hospital admissions, and increased waste¹.

It has been estimated that people aged over 65 years receive an average of 55 prescription items per year, and 36% of older people take ≥ 4 medicines regularly. NICE guidance recommends that, with respect to adherence, patients should be assessed on an individual basis. Interventions should be discussed with the patient, and tailored to address the individual's concerns and needs².



Method

A literature search and review of existing adherence assessment tools was carried out prior to project initiation. An assessment tool was devised, and modified for testing. Available adherence solutions were scoped, and a solution grid was developed, mapping adherence problems to potential solutions.

Four initial pilot areas were selected (two per trust). Referral mechanisms, including the Clinical Communications Gateway for GPs, electronic referral via Trust intranets, and faxing/posting were tested. 8 GP Practices and 22 Community pharmacies were enrolled in the pilot.

Patient inclusion criteria
Aged ≥ 65 years
≥ 4 regular medications
Living at home
Suspected medication adherence issue

For each patient referred, the pilot lead conducted a domiciliary medication adherence assessment. Prior to, and during the assessment, information was collated about the patient, their medication regimen and medical history. Adherence issues were identified, and solutions recommended to address these. Changes were recommended to optimise therapy. Summary correspondence was sent to the patient's GP. Solutions were implemented by a range of health & social care professionals, including the pilot lead(s).

Clinical interventions and adherence solutions were recorded and graded according to Eadon criteria³. The impact of clinical interventions was costed using the SchARR model⁴. Surveys were sent to all stakeholders.

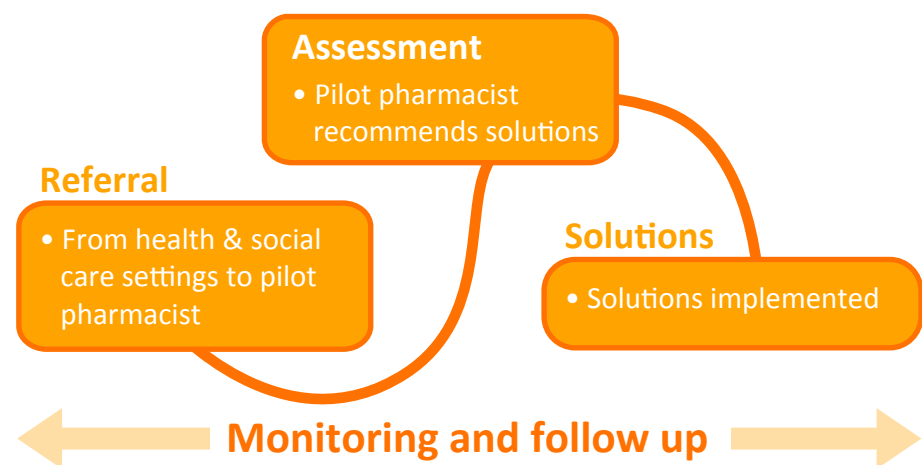


Figure 1. Service model tested in pilot service

Results

142 referrals were made to the service from primary and secondary care; 124 patients underwent a domiciliary medication adherence assessment.

198 clinical interventions were made to optimise medications; 96% of these were graded 4 or above on the Eadon Scale.

347 adherence issues were identified including non-intentional issues (difficulties with ordering, remembering to take medications, lack of knowledge, dexterity problems) and intentional issues (patient's attitudes/beliefs regarding their medication).

Solutions Recommended (n=514)	
Specific medication advice	17%
Medication change	16%
Medication disposal	12%
Medication list	12%
Synchronisation of prescription quantities and order dates	6%
Provision of a device	5%
Blister pack recommended	2%

A total of 514 solutions were recommended (average 4 per patient, range 1-12). 70% were implemented by the pilot leads.



Patients were signposted or referred to other services on 38 occasions. Potential cost avoidance was estimated at £37,965- £82,298. Follow-up data were submitted by community pharmacists for 50 patients, 65% of encounters were via the telephone. Stakeholder evaluation was predominantly positive.

Discussion

The medication adherence support service successfully provided pathways for patients identified as having adherence issues to be supported in a tailored manner to improve adherence to medication, and ultimately health care outcomes. This in turn helps keep older patients independent at home. The provision of a follow up service by community pharmacy requires further development.

References

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