

## **MONITORED DOSAGE SYSTEMS**

### **1.0 ACTION BY AWMSG:**

At their meeting on 16<sup>th</sup> March 2011 AWMSG endorsed the Aneurin Bevan Health Board process as a reasonable minimum standard for patients admitted on Monitored Dosage Systems (MDS) and requiring one at discharge.

### **2.0 PURPOSE:**

To reduce risk and variation in discharge processes in Wales for patients admitted to hospital using a MDS and requiring one at discharge.

This paper is pertinent to Recommendation 38 of the AWMSG Medicines Strategy for Wales<sup>2</sup>:

*NHS Trusts and LHBs should review their interface medicines management systems in line with best practice and develop a plan to tackle problem areas.*

### **3.0 SUMMARY:**

Patients need to be able to take their medication safely and obtain discharge medication in a manner which avoids delays in discharge and appropriately uses the resources of NHS Wales. WHC 2002 (71) outlines the appropriate supply of medication at a patient's discharge<sup>3</sup>, however many hospitals have not been able to provide medication directly to the patient at the point of discharge when a MDS is used. Alternative systems have been developed.

Ensuring a continuous supply of medication at discharge from hospital is complex when patients require a MDS. AWPAG is currently identifying data to establish the scale of the problem. The Aneurin Bevan model is however a useful example of a simpler model with fewer hand-offs compared with other models and avoids some of the communication problems. The process could be simplified further but would require considerable resources to establish a satisfactory process. The Aneurin Bevan model (see Appendix 1) is therefore proposed as an interim measure where hospitals are unable to provide discharge medication directly.

## 4.0 BACKGROUND:

The aim of MDS is to maintain patient independence, while facilitating patient compliance. It is important that individual patients are objectively assessed to ensure that a dosette is appropriate<sup>1</sup>.

The Department of Health (DoH) has stated that:

*'compliance aids and monitored dosage systems can be useful but some patients are provided with them without a proper assessment of whether they are the best way to meet their needs. Some local schemes have generally found that such aids are the best solution for only around 50% of people referred for such a service'<sup>2</sup>.*

Despite these concerns the use of compliance aids is likely to persist and could rise given the aging population and associated morbidity.

The final DOH report on care closer to home recognises that management of long term conditions is a major focal point and:

*'This includes reviewing and fundamentally redesigning the process of support and care for those with long term conditions so that the system fits around the person, rather than the person fitting in with the system'<sup>4</sup>.*

Simplification was noted to be one of several underpinning themes:

*'Counterbalancing the risk of creating extra structures and extra complexity between primary and secondary care; keeping the number of patient "handoffs" to a minimum and ensuring that every step in the care process adds value for patients'<sup>4</sup>.*

### 4.1 Models

Anecdotal evidence suggests that different mechanisms for supply across Wales are causing inconvenience or increasing risks. Current options for supply include:

- 1) Hospital dispenses discharge medication e.g. via a disposable blister pack.
- 2) Hospital faxes request to community pharmacy and GP several days prior to discharge. GP prescribes discharge medication.
- 3) Hospital prescribes discharge medication: WP10HP faxed to the community pharmacist at least 24 hours before discharge- see Aneurin Bevan Standard Operating Procedure (see Appendix 1).

Option 2 requires GPs to prescribe (and take responsibility) for a patient for whom they may not have seen for a significant period of time. They do not have ready access to patients' records or investigation. Pre-faxing discharge medication to enable timely discharge can cause problems if discharge is delayed.

Alternative options include the use of Medicines Administration Record (MAR sheets) which enables an appropriately trained carer to sign for and administer medication.

### 4.2 Hand-offs

When discharge medicines are not supplied directly from the hospital additional hand-offs occur. National Leadership and Innovation Agency for Healthcare highlight in their report that:

*'Hand-offs are the places in the patient care process where the patient, or the patient's information is passed from one member to another. Hands-offs are not only inefficient, they are also a source of clinical error and should be eliminated wherever possible'<sup>5</sup>.*

Passing the baton using the Aneurin Bevan procedure simplifies the process by not including the GP in the provision of discharge medication.

### **4.3 Delayed discharge**

Specific targets for medication review were set out in the National Service framework for older people in England, including:

*'All hospitals are to establish one stop dispensing for discharge schemes and where appropriate, self-administration schemes for medicines for older people<sup>6</sup>'.*

### **4.4 Discharge from hospital: pathway, process and practice**

The DOH report recognised some years ago that:

*'Whilst a patient is in hospital it is likely that a familiar medication pattern will be changed... Taking medication in accordance with the prescriber's instructions is an important factor in any assessment process to determine a person's ability to manage at home<sup>7</sup>'.*

Others have acknowledged that:

*'The organisation of 'take-home drugs' can also be a reason for delay when a person is ready for transfer/discharge<sup>8</sup>'.*

### **4.5 Process Mapping Group**

These concerns in relation to MDS resulted in the development of a process mapping session supported by the Welsh Medicines Partnership and lead by an independent expert. The primary remit was to consider the defined population of patients admitted on MDS and requiring one at discharge; to agree a safe process which avoids delays in patient discharge and appropriately uses the resources of NHS Wales.

## REFERENCES

1. Levings B, Szep S, Helps SC. Towards the safer use of dosettes. J Qual Clin Pract; 1999 Mar;19 (1):69-72. Australian Patient Safety Foundation, Adelaide SA. Comment in: J Qual Clin Pract. 1999 Dec;19(4):223-4.
2. Department of Health. Management of medicines - a resource to support implementation of the wider aspects of medicines management for the National Service Frameworks for Diabetes Renal Services and Long-Term Conditions; March 2007. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH\\_4892172](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4892172) Accessed February 2011.
3. Welsh Health Circular 2000 (71). FOR THE RECORD- Managing Records in NHS Trusts and Health Authorities. July 2000. Available at: [http://www.wales.nhs.uk/sites3/Documents/783/WHC\\_2000\\_71.pdf](http://www.wales.nhs.uk/sites3/Documents/783/WHC_2000_71.pdf) Accessed February 2011.
4. Ham c, Parker H, Singh D et al. NHS Institute for Innovation and Improvement. Getting the Basics Right Final Report on the Care Closer to Home: Making the Shift Programme; May 2007. Available at: [http://www.hsmc.bham.ac.uk/staff/pdfs/Getting\\_Basics\\_Right.pdf](http://www.hsmc.bham.ac.uk/staff/pdfs/Getting_Basics_Right.pdf) Accessed February 2011.
5. National Leadership and Innovation Agency for Healthcare. Passing the Baton - A Practical Guide to Effective Discharge Planning; June 2008. Available at: <http://www.wales.nhs.uk/sitesplus/829/page/36467> Accessed February 2011.
6. Health & Social Care Joint Unit and Change Agents Team. Department of Health. Discharge from hospital: pathway, process and practice; January 2003. Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4116525.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116525.pdf) Accessed February 2011
7. Department of Health . National service framework for older people: modern standards and service models; March 2001. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_40094490](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_40094490) Accessed February 2011.
8. Green, P. and Rees, L. Hospital discharge of elderly patients: is seamless care achieved? Pharmaceutical Journal; 1999: 263. [Abstract presented at the British Pharmaceutical Conference, Cardiff].

**NB: This is considered an example of good practice for patients admitted on Monitored Dosage Systems (MDS) and requiring one at discharge**

**APPENDIX 1: ANEURIN BEVAN HEALTH BOARD CURRENT PHARMACY PROCEDURES FOR THE DISCHARGE OF PATIENTS ON MONITORED DOSAGE SYSTEMS (EXCLUDING MENTAL HEALTH)**

## **Gwent Healthcare NHS Trust**

### **Pharmacy Procedures**

<b>PROCEDURE NAME &amp; NUMBER</b>	Discharge of patients on Monitored Dosage Systems (MDS) (excluding mental health)	096/05 Version 4
------------------------------------	---	---------------------

<b>AUTHOR OF CURRENT VERSION:</b> Krishna Ghosh	<b>APPROVED BY:</b> Pharmacy Management Team
<b>DATE OF ORIGINAL VERSION:</b> May 2005	<b>CURRENT VERSION NUMBER:</b> 4
<b>DATE OF CURRENT VERSION APPROVAL:</b> September 2009	<b>REVIEW DATE:</b> September 2011

**(Please refer to separate SOP for mental health patients)**

MDS's e.g. nomads, or similar compliance aids cannot be used whilst a patient is in hospital as the nurses are unable to identify the individual medicines and there is no information on batch numbers and expiry dates.

Therefore:

- Utilise stock medication rather than ordering medication for one-stop dispensing.
- If an item is not stock, then order an original pack, labelling it with directions.

The pharmacy team is responsible for ensuring the patient is discharged with appropriate medication

As soon as the pharmacy team is aware that a patient on MDS is on their ward, the patients community pharmacist should be contacted to inform him/her of the situation with the patients MDS, and explain that they will be in contact with them again when informed of discharge.

The pharmacist or MM technician must annotate the patients chart with "MDS patient" and add details of the community pharmacist, on the top left hand side of the chart.

The prescribing and nursing team must be informed that discharge planning is essential, so that the patients MDS does not cause a delay in discharge.

When notified of discharge, and after discussion with patient/carer, the pharmacy team member must telephone the patients community pharmacist to explain and agree the process (timescales etc.)

At RGH, NHH & CDMH, the pharmacist obtains a WP10HP from the pharmacy office and signs out on the appropriate form. The pharmacy office must stamp the WP10HP with the correct cost code for the Directorate

At peripheral, community hospitals, the pre-stamped WP10HP's are stored on designated wards (in the CD cupboards). The pharmacist obtains them from there. In the absence of the pharmacist it is the responsibility of the doctor and lead nurse to undertake this process.

A normal edischarge or (yellow) Trust discharge letter/prescription must be completed as usual and the medicines annotated "dispensed by community pharmacist via WP10HP" to maintain pharmacy and GP records. On e-discharge there is a 'MDS' quick link.

The pharmacist or doctor must transcribe the TTH from the edischarge or yellow discharge Trust prescription, onto the WP10HP, in a manner that the community pharmacist will understand, and obtain prescribers signature. A maximum of 28 days can be prescribed.

The completed WP10HP must be faxed to the community pharmacist within the timescale agreed (usually at least 24 hours before discharge) together with the completed covering pro-forma (below).

The pharmacy team must arrange for the postage of the original WP10HP to the community pharmacist. At RGH and NHH, details should be provided to the pharmacy office, which will produce an address sticker and post the WP10HP via registered post. At CDMH and peripheral hospitals it is the responsibility of the pharmacist or doctor/nurse to arrange postage from General Office via registered post.

Alternatively, the WP10HP can be given to the patient or carer/family to take to the community pharmacist, if this is more convenient for the patient.

The original covering pro-forma must be stapled to the pharmacy edischarge copy or yellow copy of the Trust TTH

The pharmacy team must liaise with the community pharmacist and patient if there are any delays in discharge or any changes that may impact on the supply of medicines

The pharmacy team must counsel the patient/carer on the medication, and inform the patient/carer that their community pharmacist is arranging the supply.

If on clinically checking the prescription, the MDS remains unchanged from admission, it must be returned to the patient, provided it is in an appropriate condition for use. The e-discharge must be endorsed 'MDS' and a record made under 'notes to GP', that the original was returned to the patient.

**Discharge for Patients on Monitored Dosage System (MDS)**

**Patient name & address:**

.....  
.....  
.....  
.....  
.....

**Ward:** .....

**Discharge Date and Time:** .....

**Community Pharmacy name & address:**

**General Practitioner name & address:**

**Tel No.** .....

**Tel No.** .....

**Fax No.** .....

**Fax No.**.....

**Dear Community Pharmacist**

A 28<sup>1</sup> day WP10HP is attached to this fax as discussed so that a MDS supply can be arranged in a timely manner corresponding to discharge date. The original WP10HP will be posted to you. Please can you arrange continuing supplies with the patients practice to ensure consistency of supply of medicines.

Medication changes during this hospital admission:

Medicine <sup>2</sup>	New (N)	Discontinued (D)	Altered Dose (A)

Thank you

If you have any queries regarding the prescription please contact

..... (Pharmacist/Doctor) on 01633 234234 Bleep

\_\_\_\_\_

<sup>1</sup> AWMSG members noted that a shorter duration of supply may be appropriate for patients using monitored dosage systems

<sup>2</sup> Additional space may be needed to allow for multiple medications