The Essex LPC Ultimate* 2020 Guide to Monitored Dosage Systems.

Introduction

Monitored Dosage Systems (MDS) (also referred to as Medicines Compliance Aids (MCA), Dosette Boxes or Blister Packs) present a number of challenges across health and social care.

This is largely because there is no clearly defined "ownership" or leadership of MDS: In Essex there are no commissioned MDS services, no agreed MDS pathways, no governance or assurance and no clear multi-disciplinary, multi-agency guidelines.

In turn this lack of leadership has contributed to a degree of misunderstanding and possible mistrust between professionals trying to hand off the problem to somewhere else in the system, a number of "back door" arrangements (such as 7-day prescriptions) to make up for the lack of a commissioned service, delayed hospital discharges and, unfortunately, risks to patient safety as governance and accountability is unclear.

Funding

One popular myth is that community pharmacists are funded to provide MDS to patients because "It is funded under the Disability Discrimination Act/Equality Act 2010"

This is more of a legend than a myth, in that it does have some basis in historical fact, specifically early drafts of the Community Pharmacy Contractual Framework 2005. One of the essential services was "Support for People with Disabilities" until it was gently pointed out by DH lawyers that it could have led to legal "difficulties" between pharmacy contractors and (then) PCTs.

The small amount of funding set aside for this was distributed within pharmacy's practice payments, however **this was not a payment for MDS,** it was a payment for appropriate compliance support.

Practice payments were later removed from community pharmacy funding in December 2016.

Reasonable adjustment

Compliance with the Equality Act 2010 is not just about funding, another challenge is that patients should have MDS as it constitutes a "reasonable adjustment." This **may** be the case if the patient is entirely managing their own medication (more of this later) however it does **not** apply if medicines are being prompted or administered by a paid carer as part of a care package.

In these situations the carer is the "reasonable adjustment" and MDS is not a substitute for training and an assessment of competency.

Forgetful or confused patients

There is insufficient evidence that MDS is a panacea for forgetful or confused patients, far more effective is to associate the taking of medicines with other everyday routines.

The patient needs to be **assessed** by a professional who is the expert in taking medicines, the pharmacist, who will also be aware of what other support may be more appropriate, eg reminder charts, plain white boxes, large print labels.

Oh yes, once the patient has been **assessed** and an adjustment made it is important that the assessment is **reviewed** at regular intervals, especially if the patient was initially assessed in hospital or shortly after discharge.

(Many patients are started on MDS in hospital for lots of reasons, including earlier discharge to social care, but "the hospital started it" doesn't have to be a permanent state.)

If MDS is not helping a patient then it should be stopped.

A community pharmacist cannot refuse to **assess** a patient who may need support with compliance, but they can refuse to supply medicines in MDS if, following the assessment, they do not think it is an appropriate adjustment.

Another Healthcare Professional (eg GP) can request an **assessment** but cannot insist that a pharmacist dispenses medicines in MDS.

Safety

MDS safety is a perception rather than evidence based, in fact there is a disproportionate number of safety incidents reported which involve MDS, especially where "mixed systems" are required (when a patient has some medicines in MDS and others such as liquids or inhalers that are not.)

Not all medicines are suitable for storage in MDS, they are either unstable by themselves or in contact with one or more other medicines.

Many dosage forms are unsuitable for MDS.

MDS does not distinguish medicines that should be taken before, with or after food.

Medication regimes may change mid-way through an MDS dispensing cycle.

MDS is not suitable for "as required" medicines.

Patients may have an acute prescription (eg antibiotics, corticosteroids) as well as repeat medications, and there is a risk these will be missed out if there is a dependency on MDS.

It may not be possible to visually distinguish different medicines, which compromises the patient's ability to decide not to take one or more medicines, or for one or more doses to be intentionally missed out.

Essex County Council Medicines Standards (extracted below)

"The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients in the absence of a specific need requiring a Medicines Compliance Aid (MCA) as an adherence intervention.

There is insufficient evidence to support the benefits of MCA in improving medicines adherence in patients, or in improving patient outcomes and the available evidence does not support recommendations for the use of MCAs as a default.

Each patient's needs must be assessed on an individual basis and any intervention must be tailored to the patient's specific requirements.

Request of a MCA must only be made when an assessment by a health professional (for example, a pharmacist) has been carried out, in line with the Equality Act 2010, and a specific need has been identified to support medicines adherence."

With no clear leadership on MDS the challenges seem like the fable of the blind men describing an elephant, with each stakeholder having their own version of reality.

Secondary Care Issues

- Patients are already on MDS when admitted. Meds reconciliation may not identify when, why or by whom MDS was started.
- MDS may be started in hospital as the patient prepared for discharge. They may have been assessed for medicines understanding on the ward, but they are not in their familiar surroundings. Discharge information (eg TCAM, EMOP) will just say that MDS has been started, it will not suggest a review of whether MDS is still appropriate. Once a patient is back in their own home they may well be able to manage their medicines as familiar surroundings and routines re-establish themselves.
- MDS may have been started to expedite discharge to social care (either to care home or to own home with social care support) as some homes and agencies still request this (but see below).
- Secondary care do not particularly like MDS!

GP practice issues

- Subject to demands from hospital or social care, or from patients and their family members. Practice staff and GPs need to be aware that they can request an **assessment** from the dispensing pharmacy, but they cannot insist on MDS and they cannot prescribe MDS.
- It is often the default quick fix for confused patients (either directly or requested by community nurses etc) but may not be most appropriate. Patients can also be confused by MDS, especially if they have several weeks' boxes dispensed at a time.
- Practice staff may not be aware of other options, what has already been tried, and what could be tried. Practice staff who will happily refer to Occupational Therapists for mobility support or the dieticians for nutritional support do not seem to do this for medicines-taking support.
- Practices have previously agreed with "back door" payment arrangements eg universal 7-day prescriptions for patients on MDS. **There are some patients for whom 7 day prescriptions are appropriate** (whether they also require MDS or not) but there should be a clear, documented reason for this.

Social Care agencies

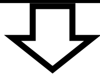
- MDS has been standard practice for some time, under the misunderstanding that staff prompting or administering medicines from MDS do not need training.
- Agencies are willing to accept that some medicines cannot be supplied in MDS, but it is a more difficult job to persuade them that none of the medicines will be supplied in MDS. This may be due to established practices, working to old policies and SOPs.
- MDS may be included in discharge brokerage etc., especially if a patient has had a stay in residential care before returning home with social care support.
- Carers collecting prescriptions are not the ones making the decision.

Community Pharmacy

- Community pharmacy has colluded with the “back door” 7-day prescription arrangements, without necessarily considering that such arrangements may not have proper governance in place.
- Community pharmacies had a financial “cushion” in the form of practice/establishment payments under previous funding arrangements, which were in part related to prescription volume. MDS for domiciliary care agencies would often be provided as it contributed to prescription volume, and pharmacies didn’t want to risk losing business to competitors.
- Since the removal of establishment payments and practice payments many pharmacies are no longer in a position to provide non-commissioned services, or additional good will services.
- Community pharmacies are increasingly subject to closer governance and scrutiny by the Regulator and NHSE & I, and there is a greater focus on medicines safety, incidents and near misses.
- With limited resources community pharmacies must prioritise eligible patients, ie those managing their own medicines and who have been appropriately assessed. Other patients who request MDS but do not meet criteria, family members requesting MDS for a relative or social care agencies requesting MDS **may be charged a fee**.

*Until something changes!

Patient identified as having problems managing medicines



- Consider simplifying regime, meds optimisation, deprescribing etc (GP, clinical pharmacist)
- Consider if problem is limited to medicines or wider cognitive impairment.
- Refer to patient's **usual** community pharmacy for compliance support

Community pharmacy assesses patient

- Consider what daily routines patient has, could taking medicines be attached to these?
- What has been tried before, which times of day most challenging?
- Consider **all** options eg alarms, reminder charts, large print labels, plain white boxes as well as MDS.
- Avoid "mixed systems" (some MDS and some not)
- **Document decision and include review date/criteria**

If assessment finds MDS most appropriate:

- This is "reasonable adjustment" under Equality Act.
- Will usually be 28 day prescription, unless clear, documented exceptional reasons for 7 day prescription.
- **Include a review date. <u>If MDS has not helped patient or improved compliance it should be stopped.</u>**
- Free of charge to patients who are managing their own medicines.

Community Pharmacies **may** charge for MDS as a private service or may refuse to fill MDS in other circumstances.

- At the request of a social care agency, residential home, sheltered housing, third sector carer etc.
- At the request of patient or family member for convenience or assurance.
- At the request of a GP, community nurse, practice nurse, Health Care Assistant.

Patients discharged from hospital (or residential home) with MDS may have been assessed by a pharmacist prior to discharge. If patient is responsible for own medication community pharmacy should reassess once patient settled back at home.

Community Pharmacies **cannot**

- Refuse to assess a patient
- Refuse to provide most appropriate compliance support based on their own assessment

GP practices cannot

- Insist a patient's medicine is supplied in MDS
- Direct a patient to a different pharmacy to obtain medicines in MDS
- 7 day prescriptions should only be issued when clinically appropriate, not solely to fund MDS: Conversely 7 day prescriptions should not be refused when appropriate.

Template letter for social care agencies.

Dear Carer

Re: Use of Multi-compartment Dispensing Systems (MDS) (Dosette boxes or Blister Packs.)

Over time there has been a move towards using more MDS packs filled by the pharmacist. These may have some advantages, but they can have some problems too.

Dispensing of medicines into MDS is only funded by the NHS in very limited circumstances, when patients are managing their own medicines without any support from a professional carer, where the medicines are stable outside the manufacturer's packaging and when they have a specific, assessed need that can only be met by use of MDS.

There is no NHS funding for MDS where medicines are prompted or administered by a paid carer, and there are no governance arrangements in place to support this.

Guidance from the National Institute for Health and Care Excellence (NICE) says that carers must be trained to administer medicines, and that medicines must be supplied with clear and simple instructions on the label that can easily be understood. This is reflected in the medication policy that Essex County Council has shared with social care providers.

We will be following this guidance and supplying medicines in the most suitable packaging according to relevant legislation and our pharmacist's professional opinion.

Please feel free to discuss this with our pharmacist and share with your employer if necessary.