NICE on medicines optimisation

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NICE recently published its new guidance on medicines optimisation. This adds to a growing range of national guidance aimed at improving the quality and safety of medication use.

The publication of this guidance is recognition of the need to respond to the mounting burden of multimorbidity, and the associated challenges of polypharmacy. A quarter of over-60s report having two or more long-term medical conditions, and rates of prescribing have increased by 50 per cent over the past decade. Attention is drawn to the King’s Fund report on polypharmacy, which emphasised the need to distinguish appropriate from problematic polypharmacy. Medicines optimisation is considered essential to supporting the management of this growing clinical complexity.

Involving patients
Medicines optimisation is defined by the NICE guidance as “a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines”. Four guiding principles are taken from the Royal Pharmaceutical Society recommendations: aim to understand the patient’s experience; evidence based choice of medicines; ensure medicines use is as safe as possible; and make medicines optimisation part of routine practice. NICE places particular emphasis upon safety and the importance of involving patients in decisions about their care.

The guideline makes recommendations in eight areas, including medication review, self-management plans, patient decision aids for use in consultations, clinical decision support, and medicines related models of organisational and cross-sector working. Three further recommendations are prioritised for implementation. The first area is systems for identifying, reporting and learning from medicines-related patient safety incidents. Multiple methods, such as record review, surveys and directly observed medicines administration, are advised. Processes should be robust and transparent, timely, involve patients, and support a “fair blame” culture. Assessing training needs, and sharing what is learned from safety issues through a medicines safety lead, is also advised.

The second priority area is medicines-related communications systems for when patients move between care settings. Processes should be both timely (ideally within 24 hours) and secure. They should address issues such as allergies, current medicines, changes to medicines, information provided to, and support required by, the patient or carer, and information such as scheduling of reviews and what monitoring patients require.

Medicines reconciliation is the third priority, defined in the guideline as “identifying an accurate list of a person’s current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately documented”. Once again, timeliness is important, and the process may need to be carried out on more than one occasion during one episode of care – eg admission, transfers and discharge. Processes should be determined locally, with a designated health professional having overall organisational responsibility.

Specifics are generally lacking from this NICE guideline, and implementation strategies are therefore likely to vary considerably with local expertise. This is perhaps unsurprising given the nature of this sort of guideline, and the lack of strong evidence for any one particular approach. The potential risk is inconsistency and, more importantly, ineffectiveness in the resulting policies employed by different organisations. The lack of evidence is reflected in the research recommendations issued at the end of the guideline. In particular, this includes establishing the clinical and cost-effectiveness of medication review, clinical decision support tools, and models of cross-organisational working in relation to sub-optimal prescribing. Nevertheless, a few specific methods are described by the guidelines. For example, the principles of the PINCER intervention are suggested as a method for reducing medicines-related safety incidents, together with the use of a safety screening tool such as STOPP/START.

In terms of improving communication, sending discharge information to a nominated community pharmacist is advocated. A number of other general approaches are highlighted which are relevant to the operationalisation of more than one of the eight medicines optimisation areas.

This guidance acknowledges the value of medication optimisation as a fundamental part of good quality, effective and safe clinical care. The recommendations made are both relevant and important. However, I suspect it will be very difficult to establish their impact on practice, and their successful implementation will require additional specific guidance supported by further research.

References
1. NICE. NG5. 2015.
2. NICE. SC71. 2014.
3. NICE. CG76. 2009.

Declaration of interests
Dr Payne is a member of the NICE Guideline Development Group for Multimorbidity

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