Getting the Medicines Right

Medicines Management in Adult and Older Adult Acute Mental Health Wards
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Acknowledgements

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Contributors

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■ The members of the multi-disciplinary reference group who helped to develop the staged model scheme
■ The members of the Advisory Board who helped to develop this report: Paul Rooney, Neil Harris, Peter Pratt and Hugh Middleton.

* Please note: During the process of finalising this publication, NIMHE was succeeded by NMHDU (National Mental Health Development Unit).
Foreword

It is often challenging to be in hospital. We are normally there because we are acutely unwell and need some extra support. What is exciting about Getting the Medicines Right is that it is showing different ways in which care can be given.

When I am admitted my mind frequently feels as if it has wandered off for a five minute break and not come back. It has reached overload and therefore even the simplest task feels like a giant mountain to climb. Getting the Medicines Right recognises that at these times we may struggle with even basic tasks like taking our medications. Staff input is invaluable here. Just as our mental health gets a complete MOT when in hospital, our physical and pharmaceutical needs require attention too.

This document encourages staff and service users to take an extra step in developing a relationship where no stone is left unturned – it is obvious from the statistics that medication non-compliance is a huge problem and therefore a key priority for action. These initiatives should help not only us patients, but staff and budgets as well.

We tend to bring our problems with us when admitted. Being in hospital is therefore the ideal environment for us to evaluate any problem areas we have had in the community. It provides a real opportunity for us to start taking some guided steps to managing our meds when discharged. I would like nothing better than to feel more confident as to what, why and when I should be taking my tablets. This document is great because it advocates the time, space and staff expertise to be able to do this. It would make such a vast difference to loved ones as well if they had the peace of mind – knowing that we have developed the skills to be able to manage the medications that help keep us well and happy – when out in the community.

The initiatives in Getting the Medicines Right encourage us to take an active role in the positive development of our medicine management and therefore in our mental health too. It is horrible feeling poorly. It is horrible reaching the low point of needing to be hospitalised. But through this document and staff support we could ensure that the time in hospital is centred around us making the most of our lives on the ‘outside’. Medicine management is key to this. I strongly endorse this publication and hope that as many people as possible can benefit from its suggestions.

Stephanie Beale-Cocks
Service User Consultant
In 2001, the Audit Commission’s report *A Spoonful of Sugar – Medicines Management in NHS Hospitals* (AC, 2001) recommended a number of specific pharmacy initiatives to help improve aspects of the provision of medicines, the monitoring of medicines and improving the safety of medicines. These initiatives included: medicines reconciliation, the use of patient’s own drugs, self-administration by patients, individualising supplies, medicines education, one stop dispensing, medicines review and enhancing clinical pharmacy.

In 2007, the Healthcare Commission published *Talking about Medicines: The management of medicines in trusts providing mental health services* (HC, 2007) which highlighted that managing medicines safely, effectively and efficiently is vital for delivering high quality, value for money care that is focused on the person using services. It made a number of recommendations to mental health trusts within ten priority areas, and this now forms a key part of local trust action plans. It stated that non-adherence to medicines is one of the key reasons for admission to hospital. So there are clear incentives, both for patients and in finance, to prioritise the development of key processes to support medicines management. Informing and involving patients with their medicines, whilst in hospital will lead to less hospital re-admissions and improve recovery.

Since 2001 many mental health Trusts have tried to implement these recommendations in acute adult and older adult mental health wards.

However, little work has been conducted to explore what elements of these medicines management schemes work best on acute adult and acute older adult mental health wards in England. This document provides:

- an evaluation of specific pharmacy led medicines management schemes proposed for adult and older adult acute mental health wards
- recommendations about the suitability of those medicines management schemes for adult and older adult acute mental health wards
- key messages from service users and carers arising from the consultation, and
- a model framework for better medicines management on an acute mental health ward.

Studies have shown that 55 to 60% of re-admissions to hospital are linked to problems with adherence. Therefore, although this document considers medicines management processes on wards, most of the findings are also applicable to community services, since supporting people through effective community services should help to avoid admissions to hospital and prevent re-admission following discharge from an inpatient unit.
Key findings regarding existing schemes

Where medicines management schemes were most successful, the following key components were present:

- **Leadership** – someone clearly in charge and agreed strategic intent at board level and at local level
- **Team working** – Involved all disciplines, not just pharmacy, and close working of all those involved with medicines management, and
- **Resources** – dedicated funding extending over a number of years, appropriate skill mix and training and starting small with a clear implementation plan.

But the success of individual schemes also depended greatly on the process that trusts undertook to develop their individual model.

Summary of key findings in relation to specific schemes:

The following aspects of medicines management schemes are most likely to be successful when introduced onto an acute adult or acute older adult mental health ward:

<table>
<thead>
<tr>
<th>Aspect of medicines management</th>
<th>Differences between acute or older adult acute ward types</th>
<th>Recommendation</th>
<th>Applicability to mental health setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines reconciliation on admission – Systems &amp; processes to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission</td>
<td>No difference between ward types</td>
<td>This is a requirement from NICE/NPSA on mental health acute wards, but also needs to be a routine part of CPA and admission to Crisis and other mental health teams</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Patient’s Own Drugs (PODs) are assessed on admission, and either re-issued for use on the ward or kept and returned to the patient, only when appropriate, on discharge</td>
<td>More likely to be self-financing on an older adult acute ward</td>
<td>It is not cost-effective as a stand-alone scheme on acute wards, but can be beneficial when combined with other aspects of medicines management</td>
<td>✔️ ✔️</td>
</tr>
<tr>
<td>One-stop dispensing – dispensing occurs on admission, so that patient has sufficient medicines for both the duration of their stay and sufficient for discharge</td>
<td>More likely to be successful on an older adult acute ward</td>
<td>A resource-intensive activity: some aspects are applicable to mental health setting, but seem more successful on older adult acute wards</td>
<td>✔️ ✔️</td>
</tr>
<tr>
<td>Aspect of medicines management</td>
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<tr>
<td><strong>Self administration</strong> – when the patient, to varying degrees – sometimes in a tiered approach – looks after and/or is increasingly involved with the administration of his/her own medicine(s) on the acute ward</td>
<td>Operation of later stages more likely to be successful on older adult acute wards</td>
<td>Every patient needs to have access to self-administration at some stage during their admission to promote recovery and develop skills in self-administration after discharge</td>
<td>■■■■</td>
</tr>
<tr>
<td><strong>Medicines education</strong> – including: medicines management training for all clinical staff, medicines education groups for patients, medicines information packs for patients and carers, face to face advice</td>
<td>No difference between ward types</td>
<td>Patients need to have access to information on medicines which is tailored to meet their diverse needs throughout their admission and stay in hospital</td>
<td>■■■■</td>
</tr>
<tr>
<td><strong>Medication for patients on leave</strong></td>
<td>Problems reported on acute adult wards with timeliness of supply</td>
<td>Trusts need to have clear, underpinning clinical procedures and sufficient planning to support rapid access to medicines for patients going on leave</td>
<td>■■■■</td>
</tr>
<tr>
<td><strong>Discharge information on medicines</strong> – supply of discharge medicines with pharmacy providing medicines information one-to-one with the patient and/or carer</td>
<td>No difference reported between ward types in success of schemes</td>
<td>Appropriate information, tailored to meet the diverse and cultural needs of the patient needs to be available across the whole acute care pathway</td>
<td>■■■■</td>
</tr>
<tr>
<td><strong>Medicines Review</strong> – may take the form of providing a concise medicine history, right through to being on a one to one basis with the patient on the ward</td>
<td>Has been successfully implemented on both types of wards</td>
<td>Medicines review needs to form a key part of the clinical pharmacy role. Patient engagement in the review is vital in promoting recovery</td>
<td>■■■■</td>
</tr>
<tr>
<td><strong>Clinical Pharmacy</strong> – provide patient care that optimises the use of medicines and promotes health, wellness, and disease prevention – usually a combination of the various aspects of medicines management</td>
<td>May need to consist of a different package depending on ward type</td>
<td>Sufficient resources need to be available to ensure clinical pharmacy is provided as part of routine care of all patients, and in line with proper clinical governance standards. Highly recommended</td>
<td>■■■■</td>
</tr>
</tbody>
</table>
Key messages from service users and carers

- An early stage of a self-administration scheme needs to be supported particularly during the final part of a stay on an adult acute ward
- Service users dislike having to wait or queue for their medicines and would prefer to be able to ask staff for their medicines when they need them
- There needs to be regular medicines education groups and pharmacy-led advice sessions run on the wards which can be tailored to meet the diverse and cultural needs of the individual
- Rapid access to prescribed medicines needs to be available prior to planned and unplanned leave from the acute ward, and
- Medicines reconciliation on admission is vitally important, with potential benefits outlined for staff and patients.

Five stage model for getting medicines management right on mental health acute wards

This document sets out a five stage development framework (pages 25-28) for better medicines management on acute mental health wards:

| Stage 1 | Laying the foundations |
| Stage 2 | Pharmacy presence on selected wards |
| Stage 3 | Evaluating and building capacity |
| Stage 4 | Reaping the rewards |
| Stage 5 | Achieving a model system and demonstrating its impact. |
Medicines management encompasses a range of activities intended to improve the way that medicines are used, both by patients and by the NHS. Medicines management services are processes based on patient need that are used to design, implement, deliver and monitor focused care, in relation to medicines. They can include all aspects of the supply and use of medicines.

In 2001, the Audit Commission published *A Spoonful of Sugar – Medicines Management in NHS Hospitals* (AC, 2001) which highlighted that medicines management is central to the quality of healthcare, and underpins many of the specific objectives set out in The NHS Plan. The report was written primarily to help acute hospital trusts identify how well they manage medicines. It addressed the main strategic challenges and issues facing hospitals in improving the effectiveness of their medicines management, and suggested ways in which potential barriers could be met and overcome. Many of the recommendations made in the report could not be applied as easily to the mental health setting.

Between 2002 and 2005, 40 Trusts were invited to undertake small projects that promoted, supported and evaluated New Ways of Working that delivered improved management of medicines and pharmacy services for people with mental health problems and their carers. This programme, called the pharmacy 'Spread Programme' was designed to initiate, oversee and provide national programmes of work within and across the mental health pharmacy workforce. The results identified that some medicines management services or methods advocated in *A Spoonful of Sugar* were neither cost-effective nor appropriate for mental health acute wards.

In 2007, the Healthcare Commission published *Talking about Medicines: The management of medicines in trusts providing mental health services* (HC, 2007) which highlighted that managing medicines safely, effectively and efficiently is vital for delivering high quality, value for money care that is focused on the person using services. It made a number of recommendations to mental health Trusts within ten priority areas. Incorporated within the recommendations were various aspects of medicines management relevant to this document.

A self-assessment tool has been developed (which can be downloaded at www.newwaysofworking.co.uk) to help mental health Trusts to understand how far they have progressed with developing medicines management, and which areas require particular focus.

However, a number of national reports (*HC, 2007, NIMHE, 2006*) have highlighted that mental health services are suffering from a significant under-investment in pharmacy, and often a lack of strategic direction in relation to medicines management, and that pharmacy should lead medicines reconciliation in acute wards. (*NICE/NPSA 2007*). These problems have inevitably influenced the ability of trusts to implement the proposals.
Aim of this document
This document is aimed to assist those involved in the planning, implementation, design and commissioning of medicines management systems in both adult acute and older adult acute mental health wards. Rehabilitation, intensive care and forensic units were excluded from the original project. It is intended to help local decision making about investment both in developing service components and new medicines procedures in acute in-patient units.

Scope and methodology
This document provides an evaluation of key medicines management activities, and suggests a 5 stage programme for developing a model acute mental health medicines management scheme. The document covers both adult acute and older adult acute mental health wards in England. Since little work had been conducted to explore the role of medicines management and what elements worked best on acute adult and acute older adult mental health wards in England, the National Institute for Mental Health in England Acute Care Programme (NIMHE) commissioned a project to evaluate medicines management schemes in mental health acute wards. The main outcomes of the work were to include:

- An evaluation of a wide range of implementations in England of aspects of or complete programme of medicines management schemes in mental health acute wards
- A summary of any evidence to support or refute the value of medicines management schemes in mental health acute wards, and
- A proposed medicines management model scheme or schemes for adult and older adult mental health acute wards.

The project delivered its findings through:
- A literature review
- Questionnaire (62% of mental health trusts in England responded), and
- Structured telephone interviews (with 20 of the main contacts for the mental health Trusts that responded to the survey, including service user/carer contacts).

Why is this document needed?
A Spoonful of Sugar (AC, 2001) advocated a number of medicines management activities for acute sector Trusts. This document reviews their suitability for the mental health acute ward setting. The Healthcare Commission (HC, 2007) also identified efficient and effective provision and administration of medicines as a key medicines management area for improvement in acute mental health services.

Who should use this guidance?
This document is targeted to all staff involved in reviewing, commissioning and providing medicines management services to local acute mental health ward services for adults and older adults. Nursing staff may find this document of particular benefit as they take a lead role in many aspects of medicines management. This guidance provides information on the range of medicines management systems and will be useful in planning and initiating new medicines management services and developments.
How to use this document

To get the best use from this document, take the following steps:

- Read through the document
- Benchmark the local service against its key findings in order to develop a local action plan
- Present the findings and proposed action plan to the Acute Care Forum

- Use the above information to inform the development of the Trust's mental health medicines management strategy.
Evaluation of key medicines management activities

Medicines management schemes include medicines supply plus any extended support service from pharmacy; it could be provided at anytime within the in-patient stay on the acute ward, from admission to discharge.

This document is based around an evaluation of the following medicines management activities:

- Medicines reconciliation
- Re-use of patient’s own drugs
- One-stop dispensing
- Self-administration of medicines
- Medicines education
- Short-term leave medicines
- Discharge counselling/advice on medicines
- Automation
- Medicines review, and
- Clinical pharmacy.

Medicines Reconciliation

**Rationale:**

The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. Details to be recorded include the name of the medicine(s), dose, frequency, and route of administration. Establishing these details may involve discussion with the patient and/or carers, scrutiny of the patient’s own medicines and the use of records from primary care. It does not include a medicines review.

The expectation is for all patients to have a medicines reconciliation achieved within 24 hours of admission (weekends permitting). Medicines reconciliation can also occur at discharge, to ensure that the service users’ medicines at home accurately represent those prescribed at discharge.

Whilst the project was being conducted, NICE/NPSA guidance was published on medicines reconciliation. This made the implementation of effective medicines reconciliation on admission a priority for all Trusts. To download go to: www.nice.org.uk/nicemedia/pdf/PSG001Guidance.pdf
Evidence base:

Research has shown that poor communication of information at transition points is responsible for as many as 50% of all medicine errors, and up to 20% of adverse medicine related events in hospital (IHI, 2007). Medicines reconciliation on admission has an evidence base to support it as an important component of effective medicines management, and NICE/NPSA has stated that its deployment should be a priority for mental health acute wards.

Survey findings:

- Of the 37 Trusts surveyed 11 had implemented medicines reconciliation to some degree. Six Trusts reported having successfully implemented medicines reconciliation on both adult and older adult acute mental health wards
- Schemes had been implemented in a range of different ways including one or more of the following:
  - pharmacy staff visit the wards each morning and check through new admissions
  - on admission the pharmacist routinely requests information from the GP and/or
  - specially trained pharmacy technicians (called medicines management technicians) do a ‘medicine continuity check’ on admission, or
  - medicines are brought in on admission checked as part of daily ward visits
  - medicines management technicians assess patient’s own medicines (PODs), and contact GP practices for further information.
- Key barriers to implementation included a lack of pharmacist and pharmacy technician availability and incomplete GP records. “As a result, in order to support reconciliation, many Trusts are moving towards the development of supporting checklists and documentation, accessible to nurses, modern matrons, pharmacy staff and doctors.

Recommendation:

Medicines reconciliation is a NICE/NPSA requirement on mental health acute wards, but also needs to be a routine part of Care Programme Approach (CPA) and admission to crisis home treatment and other community mental health teams. Any relevant equality and diversity issues need to be taken into account when discussing medicines reconciliation with patients and carers.

Patient’s own drugs (PODs)

Rationale:

Patient’s own drugs are assessed on admission, and either re-issued for use on the ward or kept and returned to the patient, only when appropriate, on discharge.

The reuse of PODs has a number of advantages. It enables the examination of the actual medicines during medicines reconciliation; it achieves cost savings particularly if the stay in hospital is short and the reason for admission does not involve changing the prescription; it reduces the risk that supplies of medicines in the home will be at variance to those on discharge; it may also provide an opportunity to evaluate compliance and reduce the need for multiple dispensing and reduces waste. Most POD schemes in acute sector hospitals are funded on the basis of medicines cost savings.

However, the benefits of the reuse of PODs are unlikely to be achieved if hospital stays are long or medicines are frequently changed, when discharge is not straightforward or when patients do not bring their medicines into hospital.
Evidence base:
There is a significant evidence base for the benefits of reusing PODs in acute sector hospitals but there is an absence of evidence in acute mental health care.

Survey findings:
- 16 Trusts responded to say that they had regular reuse of PODs. A further two respondents described their Trust having implemented PODs in an ad hoc manner and a further 2 described POD schemes that had been piloted but then abandoned.
- 11 respondents felt that POD schemes had worked well on both adult and older adult acute mental health wards in their Trusts.
- Good marketing and awareness was found to be key to the successful implementation of the POD scheme. In particular it is important to make the receipt of PODs a part of the normal admission procedure.
- There is a need for leadership from pharmacy teams, with well-trained medicines management technicians available.
- Access to drug trolleys with individualised compartments/drawers was essential. Nursing staff preferred the new style drug trolleys with one drawer per patient. The lack of suitable trolleys was cited as a reason for failed schemes, and.
- There were mixed findings about the achievement of cost savings. One had found that implementing the scheme resulted in cost savings. One described the implementation of the POD scheme as having been partially successful, but patients were not bringing in enough of their own medicines to make the scheme financially viable. One of the schemes that had been piloted, but then abandoned, was found to be labour intensive for staff with few cost savings.

Recommendation:
Patient’s own drugs is not cost-effective as a stand-alone scheme on acute wards, but can be beneficial when combined with other aspects of medicines management.

One Stop Dispensing
Rationale:
There are a number of definitions of ‘one stop dispensing’. The intention is that dispensing occurs on admission, so that the patient has sufficient medicines for both the
duration of their stay and sufficient for discharge. The scheme may include appropriate reuse of Patient’s own drugs (PODs) and dispensing of new drugs in patient packs.

The advantages of ‘one stop dispensing’ are that it reduces the need for repeated dispensing and when the dispensing occurs it is provided as complete patient packs thus streamlining the whole dispensing process. Some variations have the medicines fully labelled with the instructions for administration, which has the advantages of enabling self-administration and rapid discharge with the medicines already dispensed. Other variations provide the original packs without the instructions for administration; this avoids the needs for constant re-dispensing following each dose change but is not suitable for self-administration and requires the further generation of a label upon discharge.

**Evidence base:**

The literature review did not find evidence for one-stop dispensing as a single medicines management intervention in an acute mental health ward. There was no published work to demonstrate fewer medicines errors linked to one-stop dispensing in mental health wards.

Evidence from acute sector Trusts has shown that one-stop dispensing causes: quicker discharge, reduces pharmacy time and reduces the need for a service user to rush to see a GP to obtain further supplies of medicines after discharge. The transfer of these benefits to the mental health setting should not be accepted without evidence, due to the need for smaller supplies of medicines, and frequent changes in medicines during the ward stay.

**Survey findings:**

- 8 Trusts responded to say that they had implemented one stop dispensing on acute mental health wards. Of these, six reported that they were working successfully

- Schemes seemed to be more successful on acute older adult mental health wards, with anecdotal reports of fewer medicine errors, speedier discharge and cost-effectiveness

- Where one stop dispensing had been successful on adult wards, it had been linked to near-patient dispensing and other services such as medicines education on discharge

- General barriers to one stop dispensing included the time consuming nature of the scheme for teams with smaller numbers of pharmacy staff, poor links between ward and pharmacy staff was also problematic, with medicines failing to be returned to pharmacy, and

- On the adult acute wards, barriers included: a lack of storage facilities on the ward; no formal system or procedure to prevent nurses giving patients a full supply of medicines when they were taking short-term leave from the ward, and difficulties completing risk assessments to allow patients onto the scheme, lengths of stay not fitting with 28-day patient packs.

**Recommendation:**

One stop dispensing is a resource-intensive activity. Only certain aspects of it are applicable to mental health setting, but it seems more successful on older adult acute wards.
Self-administration

Rationale:

Self-administration is when the patient, to varying degrees (sometimes in a tiered/staged approach) looks after and/or is increasingly involved with the administration of his/her own medicine(s) on the acute ward. It is used to test and develop skills in self-administration. Patients may move both ways across stages.

In the responses from the survey, many different types of self-administration, with varying numbers and types of stages were described. Self-administration was reported as operating successfully on many different types of mental health wards including acute admission.

The differing types of self-administration reported could be grouped into the following general stages of self-administration, although Trusts may have different names for, and numbers of, stages in their local programmes:

### Table 1: Summary of general stages of self-administration

<table>
<thead>
<tr>
<th>Stage</th>
<th>Principles</th>
<th>Storage</th>
<th>Nursing requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>The patient is either unable to or it is not deemed appropriate to manage their own medicines</td>
<td>Will be within the ward medicine cabinet, medicines trolley or in the patient’s medicine locker where the nurse holds the locker key.</td>
<td>Usual nursing requirements apply. The nurse is responsible for all aspects of medicines administration</td>
</tr>
<tr>
<td>One</td>
<td>The patient will be required to attend for medicines at every dose without the need to be prompted by staff. This is considered a desired target for all attendances. The process of intervention will predominantly involve assisting the patient to select the appropriate medicines as prescribed.</td>
<td>Will be in the patient’s medicine locker where the nurse or the patient holds the locker key.</td>
<td>If the patient has failed to request his/her medicines within one hour of the prescribed time a verbal prompt will be given. Continued failure to attend for medicines despite prompts will be discussed with the multidisciplinary team who will advise the patient accordingly. The patient will be encouraged to dispense the medicines personally from the individual bottles (if dispensed thus). This process will be supervised and checked throughout by the nurse.</td>
</tr>
<tr>
<td>Stage</td>
<td>Principles</td>
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</tr>
<tr>
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</tr>
</tbody>
</table>
| Two   | The process of intervention will predominantly involve assisting the patient in the appropriate management from a 1 day to a 7 day supply of medicines as prescribed.  
   The patient is responsible for the safe and secure storage of medicines. | Will be in the patient’s medicine locker where the nurse or the patient holds the locker key.  
   The patient needs to understand that for the safety of others the medicines must be kept locked within the locker whilst the patient is on or off the ward. | Throughout the process the nurse will engage in conversation with the patient to check for understanding about the selection of appropriate medicines.  
   The patient will attend for medicines anywhere between daily to weekly to receive anywhere between a 1-7 day supply of medicines.  
   At the next occasion of receiving medicines, the medicines container will be returned by the patient. The nurse will record any return of unused medicines within the nursing notes.  
   During the supply period the nurse will, make at least one check with the patient that the medicines are being consumed as prescribed.  
   Monitoring frequency may be the responsibility of the ward manager or multi-disciplinary team. |
| Three | The process of intervention will predominantly involve assisting the patient in the appropriate management of a supply of medicines as prescribed.  
   The patient needs to be able to articulate issues concerning the safekeeping of medicines, the safety of others and the need for medicines to be kept locked in the patient’s locker. | Storage of medicines for Stage Three will be within the patient’s own locker and the patient has access to the medicines. | Attendance for medicines will occur as required and appropriate for the supply period.  
   The nurse will engage in conversation with the patient to check for understanding about the intended management of medicines for the supply period.  
   During the supply period the nurse will, as considered necessary, conduct a check with the patient that the medicines are being consumed as prescribed. This will involve counting the remaining tablets or medicines.  
   A record will be made of discussions and particular note taken regarding the patient’s attitude and continued concordance. |
Evidence base:
The literature review did not provide evidence for self-administration as a single medicines management intervention in a mental health acute admission ward. The lack of well-designed studies, flawed methodology and inadequate reporting in many papers make conclusions hard to draw in relation to the benefits of self-administration in acute sector Trusts. Conclusive evidence that self-administration improves compliance is not provided. Although patients participating in self-administration make errors, small numbers of patients are often responsible for a large number of errors. Whilst most studies suggest that self-administration increases patient’s knowledge in part, it is difficult to separate out the effect of the educational component of many self-administration programmes. Most patients who participated in self-administration were satisfied with their care and many would choose to take part in self-administration in the future. No studies in acute sector Trusts measured the total resource requirement of implementing and maintaining a self-administration programme.

Survey findings:
- 9 Trusts responded to say that self-administration was occurring on acute mental health wards. Of these, seven reported that it was working successfully.
- Many Trusts reported providing self-administration to patients on wards other than acute admission: e.g. secure units, rehabilitation.
- All schemes had entry criteria, with robust risk assessment, so that only some patients would be receiving self-administration on a ward. Patients who would be leaving for residential care were not usually deemed suitable.
- Pharmacy support was a key component of successful self-administration, as was planning soon after admission, and strong partnerships with nursing staff. Standard operating procedures, so that it could operate at all times, and the importance of sufficient numbers of trained pharmacy staff to support the scheme at ward level were also critically important.
- All schemes consisted of a number of stages, but there was great variation nationally about the number of stages in operation, and what constituted each stage.
- Successful self-administration schemes were reported for acute adult and older adult wards, but it was more common for only early stages to operate on acute adult wards. Where utilised, it was felt that service users had left hospital with easier access to their own discharge medicines and had needed less support in the community regarding their medicines. It was felt helpful to establish exactly what people were doing with their medicines, to support the assessment process, and to prevent patients from becoming institutionalised. Further research is needed to assess the long-term benefits for service users, and
Key barriers outlined to success were: a lack of suitable equipment (e.g. lockers, suitable drug trolleys); difficulties engaging nursing staff with the scheme; lack of pharmacy leadership; unclear benefits that could be realised from the scheme; specific barriers on adult acute wards about the risks associated with the scheme, (if all tiers operated), regarding the potential for the scheme to be abused, with patients trading medicines and bullying other patients for their medicines; difficulties in getting patients to sign up to the scheme and take responsibility for their medicines; the pattern of admission to these wards changing with more acutely unwell patients being admitted for shorter periods of time leading to a barrier to the full implementation of this scheme (later stages not reached); risk assessments often resulting in small numbers of patients being suitable for the scheme, and a lack of nursing capacity on acute wards preventing the implementation of the self-administration scheme beyond early stages.

Recommendation:

Every patient needs to have access to self-administration at some stage during their admission to promote recovery and develop skills in self-administration after discharge.

Medicines education

Rationale:

Medicines education took a number of guises, including: medicines management training for all clinical staff delivered by pharmacists, medicines education groups run for patients by technicians or pharmacists and supported by nurses and medicines information packs for patients and carers supplemented by face to face advice upon request.

Evidence base:

The literature review did not provide evidence for medicines education, delivered by pharmacy staff, as a single medicines management intervention in a mental health acute admission ward. There was some evidence of the benefit of medicines education provided to mental health service users in the community.

Survey findings:

- Medicines education was usually delivered as part of other schemes rather than a stand-alone intervention, and
- Medicines education is highly valued by service users and carers, but needs to be developed in partnership between pharmacy and nursing staff.

Recommendation:

Patients need to have access to information on medicines during their admission and throughout their stay in hospital. All medicines information provided needs to take into account that individuals may have different cultural perspectives regarding medication compliance, depending upon their age, gender, disability, race, sexual orientation, belief or religion. This needs to be understood in order to be able to provide an effective personalised approach.

Medicines for patients on leave

Rationale:

It is common practice for mental health wards to provide patients with short periods of trial leave from the ward prior to discharge. Pharmacies are required to
provide small quantities of medicines for these short-term leaves

**Evidence base:**

The literature review did not provide evidence for services around short-term leave as a single medicines management intervention in a mental health acute admission ward

**Survey findings:**

- There can be problems in patients receiving short-term leave medicines in a timely manner, particularly at weekends or outside of normal pharmacy hours. This was reported as a frequent problem by service users and carers. This can be improved by:
  - transferring the requirement for authorisation for dispensing of short-term leave medicines to nurses, pharmacy technicians or pharmacists, dispensing occurring directly from an in-patient chart rather than requiring an additional medically written prescription.
  - pharmacy technician managed schemes
  - clinical pharmacist attendance at the multidisciplinary team meeting where leave is discussed

- Short-term leave was commonly reported as creating a problem to deliver in a timely fashion and being a barrier to implementing other aspects of medicines management

- Increasingly, patients going on leave may be more acutely unwell than in the past. Concerns were expressed about:
  - patients taking short-term leave medicines from the ward as a 28 day dispensing pack, and forgetting to bring the medicines back with them
  - risk assessment was necessary to prevent patients leaving with inappropriately large quantities of medicines for short-term leave

- on discharge, ward staff would sometimes forget to send medicines back to pharmacy, and

- To address these barriers, education, awareness and specific procedures were necessary across the wards, with the pharmacy team being involved with patient reviews, leave planning and the use of nurse/pharmacy written leave forms resulting in quicker availability of leave medicines.

**Recommendation:**

Trusts need to have clear underpinning clinical procedures and sufficient planning to support rapid access to medicines for patients going on leave.

**Discharge information on medicines**

**Rationale:**

This involves the supply of individually dispensed discharge medicines with an extended pharmacy service providing information/education about the medicines supplied to the patient and/or carer on a one-to-one personalised basis to meet their diverse needs.

**Evidence base:**

The literature review did not provide evidence for discharge information on medicines, delivered by pharmacy staff, as a single medicines management intervention in a mental health acute admission ward.

**Survey findings:**

- 9 Trusts reported that pharmacy provided discharge information on medicines
through formal schemes, and four reported that these were successful. The remaining five Trusts reported schemes being only partly successful or unsuccessful (see barriers below).

- Some schemes were ad hoc (available on request), while others were more formal and linked other services like medicines education, one-stop dispensing and enhanced communication of discharge medicine summaries.

- A few utilised the skills of pharmacy technicians and nurses with the support of pharmacists in order to provide a formal service.

- Schemes were perceived as successful on both older adult and adult acute mental health wards, and

- Barriers to success were: a lack of staff time, in particular the availability of a pharmacist, the high rate of unplanned discharge on adult acute mental health wards and the significant resources required to provide ward level support.

**Recommendation:**

Appropriate medicines information, which can be tailored to meet the diverse and cultural needs of the individual patient needs to be available across the whole acute care pathway including any inpatient admission and stay in hospital.

**Evidence base:**

Automated dispensing machines appear to be the most suited to the type of dispensing used in Trusts, but there are no published trials in the UK.

**Survey findings:**

- There is one on-going trial within a mental health Trust in the UK.

- Since dispensing to acute admission patients often requires supply of small quantities, the issue of automation did not form a discussion point within any of the telephone interviews, or arise in the questionnaire responses, and

- Automation, in the form of robotic dispensing, is increasingly used in acute sector Trusts, where patient pack dispensing is uniformly practiced.

**Recommendation:**

It is too early to make a clear recommendation about automation.

**Automation**

**Rationale:**

There are currently two main types of automation: robotic dispensing utilised in acute sector Trusts and automated dispensing machines.
Medicines Review

Rationale:
Medicines are reviewed through an extended pharmacy service. This may range from being without the patient/carer being present, and may take the form of providing a concise medicine history, right through to the review being on a one to one basis with the patient (and carer) on the ward. The purpose of the review is to inform and guide the future choice of medicines for the patient.

Evidence base:
The literature review did not provide evidence for medicines review, delivered by pharmacy staff, as a single medicines management intervention in a mental health acute admission ward, although there is some evidence in a community mental health setting. Medicines review has been shown to play an important part in falls prevention.

There has been recent emphasis on the need for regular review of treatment, particularly in older adults, and a growing awareness that many medicine-related problems can be avoided with increased vigilance and intervention by the health care team.

A number of clinical trials in the UK and North America have shown the benefits of pharmacists reviewing long term prescriptions in community practice. Many problems with medicines could be prevented by monitoring the effects of long-term therapy, by identifying those at risk, and by modifying their medicines where necessary.

Survey findings:
- Of the 37 Trusts surveyed 17 had implemented some aspects of medicines review, and 7 reported that it was totally successful (the others reported only part success or no success)
- Medicines review had been successfully implemented on both adult and older adult acute mental health wards. Ward visits by pharmacy staff, attendance at multidisciplinary team meetings plus the production of detailed medicines histories and recommendations on request were all successful elements of these schemes, which was felt to increase the status of pharmacy and raise the profile of pharmacy for patients. One of these schemes provided a full medicines review for all new admissions and had 9 pharmacists working on wards to support this, and
- Barriers to medicines review schemes included a lack of capacity within the pharmacy team to provide such detailed reviews to all patients; some stated these reviews were conducted on request.

Recommendation:
Medicines review needs to form a key part of the clinical pharmacy role. Discussing, informing and guiding the future choice of medicines with the patient is also important in achieving positive engagement through a whole-person approach which promotes recovery.
Clinical Pharmacy

Rationale:
Clinical Pharmacy is a health science discipline in which pharmacists provide patient care that optimises the use of medicines and promotes health, wellness, and disease prevention.

Within the system of health care, clinical pharmacists are experts in the therapeutic use of medicines. They routinely provide medicines evaluations and recommendations to patients and health care professionals. Clinical pharmacists are a primary source of scientifically valid information and advice regarding the safe, appropriate, and cost-effective use of medicines.

Evidence base:
The systematic literature review showed a significant positive patient outcome from specialist mental health pharmacists providing a number of clinical services as a package on an acute ward. The pharmacy package included attending treatment team meetings, performing baseline assessments, weekly reviews, medicines recommendations, medicines histories, medicines reviews, monitoring for adverse drug reactions, medicines education classes and discharge advice on medicines.

There was no published evidence that supported specific single interventions by pharmacy teams in an acute mental health ward setting.

Survey findings:
- Of the 37 Trusts surveyed, three had introduced a number of schemes as a package of changes, rather than stand-alone services, and most were slowly developing clinical pharmacy services delivering a small number of aspects of medicines management, and
- A minority (seven) lacked the basic components of a clinical pharmacy service.

Recommendation:
Sufficient resources need to be available to ensure Clinical Pharmacy is provided as part of routine care of all patients in line with proper clinical governance standards.
Summary of the suitability of aspects of medicines management for mental health acute wards

From the evaluation, we can identify which aspects of medicines management are most likely to be successful when introduced onto an acute adult or acute older adult mental health ward.

However, the results from the structured interviews suggest that many are inter-related, and that Trusts may be best placed to introduce them as a package onto a ward, rather than grow schemes one by one, so that medicines management, as a ward package, is rolled out across wards. There may also be changes in the package, dependent on the type of acute ward, since some aspects are more successful on older adult acute mental health wards than on acute adult. Nurses are the largest professional group working at ward level and will be key partners in developing ward-based medicines management initiatives. It would be advisable to develop a project team to develop medicines management services.

Table 2: Suitability of aspects of medicine management schemes

<table>
<thead>
<tr>
<th>Aspect of medicines management</th>
<th>Acute mental health ward</th>
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<tbody>
<tr>
<td>Medicines reconciliation on admission</td>
<td>▪ NICE/NPSA requirement</td>
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| Patient's Own Drugs | ▪ Advantages probably outweigh the disadvantages  
▪ Aids medicines reconciliation  
▪ More likely to be self-financing on older adult wards than adult acute wards |
| One-stop dispensing | ▪ Inter-related to self-administration, PODs, and discharge information.  
▪ More likely to be successful on older adult than acute adult wards, but needs resources, e.g. storage, pharmacy capacity, training |
| Self-administration | ▪ A variety of models operating nationally.  
▪ Operation of early stages only more likely to be successful on acute adult wards, whilst later stages are also likely to be successful on older adult wards  
▪ Promotes recovery and skills in self-administration after discharge  
▪ Valued highly by patients and carers |
Key issues arising from the evaluation

The following key issues regarding medicines management schemes in mental health acute wards were raised during the survey:

- Benefits from clinical pharmacy were realised when specific schemes played a role in raising the profile of pharmacy teams (helping the integration), when good links with GPs were promoted and when schemes incorporated a thorough examination of medicines on admission via medicines reconciliation and review, admission history taking, and assessment for entry to self-administration schemes.

- The Care Programme Approach (CPA) could be utilised to include full details of medicine requirements, any changes to medicines, as well as a detailed outline of reasons for these changes.

- Full sign-up from ward staff, doctors and the multi-disciplinary team, including community staff members, is necessary for any successful medicines management scheme. Findings from cost-benefit analysis suggested that a wide range of clinical pharmacy services was more likely to make cost savings than specific schemes, although few of the specific schemes had analysed any impact on cost.

- The current small capacity of many pharmacy teams, within Trusts, rules out labour intensive schemes (e.g. involving individual dispensing), which require specific pharmacy team involvement on the acute mental health wards in the majority of Trusts. For those Trusts with low numbers of pharmacy staff, services that can be pharmacy-led but rolled out by ward staff, with referral to the pharmacy service when necessary, are appropriate.

<table>
<thead>
<tr>
<th>Aspect of medicines management</th>
<th>Acute mental health ward</th>
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<tbody>
<tr>
<td>Medicines education</td>
<td>- A variety of models</td>
</tr>
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<td></td>
<td>- No difference between ward types</td>
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<td></td>
<td>- Valued highly by patients and carers</td>
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<tr>
<td>Medication for patients on leave</td>
<td>- Specific problems reported on adult acute wards about the lack of rapid access to medication need to be prioritised for resolving</td>
</tr>
<tr>
<td></td>
<td>- High priority for patients and carers</td>
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<tr>
<td>Discharge information on medicines</td>
<td>- No difference reported between ward types in the success of schemes.</td>
</tr>
<tr>
<td></td>
<td>- Success often inter-related to medicines education, self-administration, and one-stop dispensing</td>
</tr>
<tr>
<td>Medicines Review</td>
<td>- Has been successfully implemented on both types of wards.</td>
</tr>
<tr>
<td></td>
<td>- Problems occur with pharmacy capacity, so triage/referral system may be necessary</td>
</tr>
<tr>
<td>Clinical Pharmacy</td>
<td>- Strongest evidence base. Highly recommended</td>
</tr>
</tbody>
</table>
This position emphasises the need for pharmacists and nurses to develop robust partnerships in initiating and maintaining medicines management ward-based services. For Trusts with more pharmacists and technicians available, a pharmacy presence could dismantle barriers associated with training, full sign-up and awareness. The attendance of pharmacy team members at ward rounds and multi-disciplinary meetings as routine practice would promote the service fully.

- **Medicines reconciliation** needs to occur not just on admission to wards, but across care boundaries.

- **Enhanced pharmacy input** across wards, multi-disciplinary and community teams is vital, including pharmacy technician /assistant technical officer support where possible to enhance the pharmacy presence and skill-mix on wards.

- **Increased clarity of roles** and improved communication pathways between pharmacy departments and ward-based nurses are needed.

- **The involvement of pharmacy at every stage**, from admission to discharge and beyond, rather than crisis-led input was recommended.

- Roll-out of training about medicines and medicines management to ward staff and multidisciplinary team members would support any medicines management scheme.

- The comprehensive availability of medicines information and advice to patients and carers is essential.

- **Enhanced awareness of pharmacy services and partnership working** with ward staff is vital, and

- **Key barriers to implementation** included:
  - inappropriate training for the various types of pharmacy staff
  - inadequate funding for pharmacy services
  - low numbers of pharmacy staff/capacity
  - the acute ward environment
  - poor records for mental health clients, and
  - lack of full sign-up or multidisciplinary team involvement.

### What is important to service user and carers

Telephone interviews conducted with service users and carers identified the following aspects of medicines management that they thought were most important on the acute admission ward:

- **An early stage of a self-administration scheme** needs to be supported on all acute mental health wards, particularly during the final part of a stay on an adult acute ward. Service users dislike having to wait or queue for their medicines and would prefer to be able to ask staff for their medicines when they need them.

- **There needs to be regular medicines education groups and pharmacy-led advice sessions** run on the wards which can be tailored to meet the diverse and cultural needs of the individual.

- **Rapid access to prescribed medicines** needs to be streamlined prior to planned and unplanned leave from the acute ward environment. To enable this, early pharmacy involvement in planned leave, a technician-led dispensing service (preferably on the ward), and use of pharmacy/nurse written leave forms are helpful. This would also address difficulties with ‘out of hours’ access, and limited pharmacy opening-hours, and

- **Medicines reconciliation on admission** is vitally important, with potential benefits outlined for staff and patients.
A model framework for better medicines management in mental health

A five-stage process to assist the development of a model scheme is outlined below, which allows Trusts to assess where they are regarding the development of medicines management in their acute mental health wards, and can also help plan and prioritise what aspects of medicines management could be further developed. It may be used in conjunction with the Medicines management Self-Assessment Tool developed by NIMHE (2008). This can be downloaded from: www.its-services.org.uk/silo/files/medicines-management-self-assessment-toolkit2008.xls.xls with companion guidance document from: www.its-services.org.uk/silo/files/medicines-management-self-assessment-toolkit-guidance2008pdf.pdf

Stage 1 Laying the foundations

- Establish clear medicines management leadership at a strategic level and at ward level, and clear strategic intent about the development of medicines management schemes on acute mental health wards

- Identify how pharmacy staff can be released to acute mental health wards, for example:
  - Recruit staff with mental health specialist clinical skills
  - Recruit pharmacy technicians qualified to check dispensing of other staff
  - Recruit pharmacy technicians with additional training in medicines management

- Identify the training needs for the whole team involved in aspects of medicines management (which also needs to incorporate raised awareness training regarding relevant equality and diversity issues for patients). Consider:

  The Pharmacy team
  - pharmacist post-graduate clinical pharmacy diplomas and/or post-graduate mental health pharmacy qualifications
  - pharmacy technician accredited checker training, university accredited medicines management modules for technicians
  - pharmacy Assistant Technical Officer (ATO) NVQ training

  The Ward team
  - medicines management training for nurses
  - training required to introduce specific schemes
  - nurse training to enable the initiation of short term leave medicines
Develop local project teams to assist in the development of medicines management initiatives, new services for patients, training programmes, competency assessments and systems for supporting nurses undertaking medication-related tasks, administration, education and assessment.

Identify the impact of implementation of medicines management on other ward staff.

Identify the aspects of medicines management that are prioritised to form a basic package, and the roles and responsibilities related to delivery which will be required for this to be successful.

Identify a pilot ward(s) for the package to be established on. It may be useful to have different types of wards included (with packages varied as required). The number and choice of pilots will depend on local circumstances, but should form a local trial to see if the package is successful.

Develop a Trust-wide formal policy/standard operating procedure on admission to allow PODs to be checked for suitability and re-use by pharmacy technicians or ward staff, as appropriate, including financial planning around the resources required (e.g. suitable storage), and

Promote pharmacy services with visible information material placed on all the wards. Any information needs to include a point of contact for pharmacy as well as a full list of all personnel connected with pharmacy services. Accessible multilingual information may also need to be available depending on the ethnicity of the local population.

Stage 2 Pharmacy presence on selected wards

Pharmacists are members of the ward multi-disciplinary team (MDT) Key partnerships with nurses will enable the identification of any medicines issues or difficulties. Nurses play a major role in many of the areas of medicines management and pharmacists can take a lead in ensuring that services are developed and enhanced by helping them to improve practice.

Pharmacists can perform a useful supporting and advisory role to nurses regarding their patient’s regimens, administration options and delivery of information packages.

Provide a full package of information for ward staff (nurses and Allied Health Professionals and doctors) prior to the introduction of the schemes, including seminar sessions to promote schemes and dismantle any barriers.

A pharmacist participates in ward rounds or multi-disciplinary meetings (MDM) as routine where capacity allows. A two way referral system is initiated to enable the pharmacist to highlight any concerns prior to a ward round/MDM and for a care co-ordination review form to be forwarded to the pharmacy team following the ward round/MDM.

Develop a system to permit quick access to medicines for short-term leave. Nurses, technicians or pharmacists write short term leave forms and forwards them to pharmacy, accompanied by a technician-led dispensing service. Pro-active communication with pharmacy needs to exist in relation to planned leave.

Integrate the pharmacy team with ward and MDT at all stages of ward stay, from admission to discharge, not just as a reactive response, and
Develop a medicines management acute care pathway which includes pharmacy input onto the ward. This also needs to be developed with patient and carer involvement to ensure that it is designed to meet the cultural and diverse needs of the individual.

Additional good practice developments:

- Implement an early stage of a self-administration scheme, where patients are encouraged to request their “as required” (PRN) and regular medicines at the appropriate time(s), operated by ward staff and supported by the pharmacy team, based on acute wards. Further stages may be possible for selected patients, particularly, on older adult acute wards, so that they effectively manage their own medicines prior to discharge.

- Crisis teams link to self-administration initiation on the ward, and systems ensure that patients assessed as ‘green/ ready for leave’, are receiving an early stage of self-administration prior to leave.

- Roll-out pharmacy team-led medicines management training, including information about the importance of attitudes and knowledge about medicines to all ward staff, members of the multi-disciplinary team, junior doctors, community team members and CPA coordinators.

- Provide accessible multilingual information about all prescribed medicines to patients, carers, named nurses and junior doctors. This will take into account an individual’s cultural background, first language, age, gender, disability, race, sexual orientation, belief or religion. Place information about prescribed medicines in patients’ notes/ care plans, and

- Provide medicine education groups with patients and carers, including service users and carers currently in the community. This will also take into account different cultural, social and equality issues within the local community regarding medication compliance.

**Stage 3 Evaluating and building capacity**

- Carry out a full evaluation of cost benefits associated with the introduction of new aspects of the medicines management scheme.

- Carry out an evaluation of service user experience, including the key benefits of medicines management services realised by service users after their discharge from hospital.

- Obtain feedback from staff associated with the scheme, including ward staff, community staff, GPs and community pharmacy.

- Amend the package of medicines management schemes in light of the findings of the evaluation.

- Develop a roll-out programme to other acute mental health wards. Business planning, cost effectiveness predictions, and training packages to support the pharmacy and ward teams are built into the programme prior to its roll-out, and

- Enable the professional development of staff to ensure that there is safe and effective medicines management on the ward. Provide pharmacy input to in-service training and localised ward-based training and supervision.
Stage 4 Reaping the rewards

After the roll-out programme is complete, consider how the package may be further improved. Establish any enhancements by initially piloting and evaluating on a small number of wards. The New Ways of Working for Mental Health Pharmacists document proposed a wide range of enhanced roles suitable for mental health acute wards. Enhancements will depend on the constituents of the basic ward medicines management package, but may include:

- medicines discharge summaries
- involvement with the supervision and interpretation of laboratory results
- pharmacist or nurse prescribing
- carer medicines groups, and
- clearer and more robust partnerships between nurses and pharmacists.

Stage 5 Achieving a model system and demonstrating its impact

- Carry out regular contribution/intervention studies. This will demonstrate how well Pharmacy staff are integrated into ward teams, and whether they are key to decisions about medicines at ward level.
- Carry out regular patient satisfaction audits regarding the medicines management systems which have been implemented and amend the package in light of the studies and audit findings.
- Patients routinely have the opportunity to undertake self administration on all acute wards, and
- The following medicines management systems are in place on all acute wards:
  - medicines reconciliation occurs on all admissions within 24 hours
  - rapid access to medicines on leave and discharge available
  - medicine review is available and occurs routinely, and
  - Pharmacist-led medicines summary letter are generated on discharge.
Concluding remarks

This project sought to outline the current medicines management schemes implemented across acute adult and older adult mental health wards in England, as well as suggest a model scheme for these wards. Evidence from this study suggests that acute mental health wards have implemented a range of such medicines management schemes, to varying levels depending on the type of ward, facilities available and pharmacy capacity.

There has been little formal evaluation conducted to assess the impact and success of these schemes. Communication about successful, and less successful, medicines management schemes for the acute mental health environment could be much improved to promote the sharing of best practice. There is a key role for further research and development to inform future developments in this area, and pharmacy teams would be well served to contact local research and development leads for support with this process.

Many of the proposed services, particularly medicines reconciliation and clarifying the prescription, lend themselves to the work of crisis teams. In the ideal world medicines reconciliation would be completed as part of the crisis intervention prior to admission – a future role for the mental health pharmacy team. An evaluation of the medicines management activities being undertaken by community mental health teams including Assertive Outreach, Early Intervention and Crisis would further understanding about the support currently offered within the community. It would be particularly interesting to discover whether those factors associated with successful medicines management schemes on the acute wards are also successful when delivered in the community.

The acute ward environment provides the opportunity for patients to learn about their medicines, and to establish the most appropriate medicines regimen for their mental health condition. However, this work will only be beneficial in the long-term if service users are supported within the community to focus on medicines management. It would be of particular benefit to focus such work on specific teams working with service users who may be experiencing difficulty with medicines concordance, or those recently diagnosed with mental health difficulties. This needs to be an integral part of CPA. To be successful in this work, it will be essential for pharmacists and nurses to develop closer working partnerships, sharing information and expertise, and developing systems of medicines management which will benefit service users.

This project has highlighted the importance of clear communication networks for effective co-working between pharmacy teams and the acute wards, but further work needs to focus on improving communication across acute wards, primary care and community services to fully meet the needs of service users and carers with respect to their medicines. Input from community staff and recently discharged service users has been suggested as one means of enhancing communication between inpatient and community services, but the format of this input requires further detail. The potential for peer support within the community could also be explored as a potentially valuable resource for former inpatients to increase their knowledge about their medicines as well as share their experiences of medicines and medicine-taking.
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<thead>
<tr>
<th>Abbr</th>
<th>Description</th>
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<td>AC</td>
<td>Audit Commission</td>
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<tr>
<td>ATO</td>
<td>Assistant Technical Officer</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HC</td>
<td>Healthcare Commission</td>
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<td>Institute for Healthcare Improvement</td>
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The National Mental Health Development Unit (NMHDU) is the agency charged with supporting the implementation of mental health policy in England by the Department of Health in collaboration with the NHS, Local Authorities and other major stakeholders.