A new medication review guide from NPC Plus and the Medicines Partnership will benefit both pharmacists and patients

Nina Barnett and Lelly Oboh evaluate the new medication review guide, which has been developed to clarify and define the types of review that should be conducted, and emphasises the importance of patient involvement in medication review decisions.

Introduction

NPC Plus together with the medicines partnership programme have recently produced *A guide to medication review 2008,*[1] which updates the original *Room for review*[2] document produced in 2002. This document addresses the issues of both providing and commissioning medication review (MR) services. The original definition of MR is reiterated and acknowledges the continuing confusion about different kinds of MR, given that there is still no national standard definition for the UK.

The document reminds the reader of the original four levels of review (levels 0–3). It expands on how these levels have been included in other frameworks. This includes the Quality and Outcome framework (QOF) for GPs, which requires at least level 2 reviews in relation to the medicines management indicators 11 and 12. The guide recognises that other developments, such as medicines use review (MUR) and dispensing review of use of medicines (DRUM) do not fit into the original framework and that the reviews in the hospital setting are also varied.

New classification of MR is proposed

A guide to medication review introduces a new classification for MR. It describes three TYPES of MR related to the PURPOSE of the review as follows:

1. Prescription review. The prescription review is intended to identify prescription anomalies such as duplicate prescribing, identifying potential safety issues such as drug interactions, monitoring requirements, medicines reconciliation in hospital (or at transfer of care in between settings)

identifying under- or over-prescribing and supporting cost-effective changes in prescribing. Therefore, it could be undertaken at transfer of care where review of a class of medicines is required or in an acute setting. It may also be carried out as part of the preparation for a QOF medication review or to trigger the need for other types of medication reviews.

This type of review does not require the patient or their clinical notes to be present at the review nor for all medicines to be considered, although they may be included.

2. Concordance/compliance review. This review addresses medicines-taking behaviours and covers all medicines and conditions as they relate to use of medicines. It is designed to discover patient views of their medicines and their willingness to take them. Patients are usually present but their clinical notes are not required. This type of review can be done as part of a MUR, DRUM, single assessment process (SAP), or medicines reconciliation in hospital or at long-term condition clinics. This type of review has potential benefits for patients with long-term conditions especially when drug therapy has been started or changed, or after discharge, to check if they are taking their medicines appropriately or adapting well to any medicines changes. It can provide valuable information for QOF review or clinical medication reviews.

3. Clinical review. This review includes consideration of all the medicines taken and of the clinical condition of the

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patient related to the medicines. It must be undertaken with the patient and with their clinical notes present to get a holistic view of the appropriateness of the medicines in relation to their conditions. This type of review is required at diagnosis of a long-term condition and should then be repeated regularly and as required. It can be undertaken for patients experiencing an adverse effect, where the clinical need for a medication has changed, where the patient wants to discuss therapy, if patients have stopped taking their medicines or if they request a review. The review should be conducted by the prescriber or a practitioner with defined expertise in particular area (specialist practitioner) and although it usually includes all of the patient's medical conditions, the extent to which each area is covered may vary as appropriate to the practitioner and patient situation.

A guide to medication review 2008 highlights the need for patient involvement in their MR decisions much more than in the original 2002 document.[1,2] There is much discussion on the importance of engaging patients in MR, which is useful for practitioners who are new to the service. The document covers shared decision-making, clarity of purpose of the review and details the preparation for the review required by both the practitioner and the patient.

Although most MRs are currently undertaken by doctors, the document mainly provides examples of pharmacy-led MRs from both primary and secondary care.

The final section of the guide focuses on commissioning, discussing innovation in light of 'World Class Commissioning', relating this to local needs, current services, recognition of gaps and how to address them. It gives useful tips on targeting reviews to specific populations or situations as well as monitoring process and outcomes.

Key points

This guide introduces new concepts in MR. The three 'types' of review go a long way to addressing the misunderstanding of 'levels' where practitioners may have erroneously considered that a higher number of the level was a better quality MR. The new document focuses on 'fit for purpose' reviews, emphasising the appropriateness of the review for the purpose and the importance of patient involvement. For example, even though type 1 reviews do not require the patient to be present, the guide states that changes should be made with patient involvement and consent.

The document does not go as far as to emphasise that effective communication between the practitioner and patient, and between carers and health and social care professionals is essential for effective MR. However, the examples cited within the document highlight the importance of integrating MRs into other patient care pathways and the need for robust systems locally to ensure that non-medical staff carrying out reviews are able to communicate and refer to others and *vice versa*. The adequate transfer of information to and from GP systems, such as medication history, previous medication issues or adverse effects, medicines-taking behaviour or previous MRs will all contribute to maximising the benefit of MRs.

The document does not address the potential for the patient to be undecided about medicines-taking, especially if they have not had the opportunity to discuss their concerns during prescribing. Medication review discussion should bring out any ambivalence and support patients in making an informed decision about what is best for them. It is important that practitioners should be able to facilitate this type of decision-making, because concordance decision-making is central to MR, given that patients have the ultimate veto in the form of not taking the medicines as prescribed, or at all.

Health professionals involved in medication review will benefit from the new guide and can use the classification of types of review as part of their personal medication review 'tool kit'. This version has developed significantly since the 2002 document and has been informed by progress. However, practitioners must bear in mind that every patient will need to be part of a medication review tailored to their own needs. There is no substitute for holistic review of every patient, discussing the use of and requirements for medicines in the context of their life.

Key messages

- ☐ The process of medication review is enhanced by *A guide to medication review 2008.*
- ☐ It focuses on 'fit for purpose' reviews.
- ☐ Practitioners should use their skills to tailor medication reviews to their patients needs.
- ☐ Optimal review requires good communication with other health and social care professionals and good communication with the patient both during and after the review. ✤

Declarations of interest

The authors have no interests to declare.

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