Medicines management – an introduction to non-medical prescribing 2000 word case ...

Business, Management

1. INTRODUCTION

1. 1 . MEDICINES MANAGEMENT

Medicines management can be defined as;

"…a system of processes and behaviours that determines how medicines are used by the NHS and patients."

(National prescribing centre, 2002, P1).

According to Dr Michael Dixon chair of the NHS alliance, Medicines management services are the processes for designing, implementing,

delivering and monitoring patient-focused care, based on need, and include all

aspects of supply and therapeutic use of medicines within healthcare settings.

" Poor medicines management within organisations can lead to low public confidence inhealthservices, unaddressed health needs and unsatisfactory patient outcomes and can lead to unscheduled emergency admissions orfailureto maintain independence in the community leading to re-admission to hospital and other acute care settings. It can also lead to organisational issues such as, unmet targets, inappropriate allocation of resources, inefficient services, and risk."

(Calderdale pct, 2004)

“ Good medicines management means that patients receive better, safer and more convenient care. It leads to better use of professional time and enables practitioners to focus their skills where they are most appropriate. Effective medicines management also frees up resources which means that NHSmoneycan be used where it is most effective. Good medicines management benefits everyone.” (http://www. npc. co. uk/mm/index. htm)

1. 2 . NON-MEDICAL PRESCRIBING

“ Non-medical prescribing is prescribing by specially trained nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers, working within their clinical competence as either independent or supplementary prescribers.” (http://www. npc. co. uk/prescribers/resources/NMP_QuickGuide. pdf)

The Department of health recognised that non-medical prescribers are a large and growing workforce. They found that by the end of 2009 there were over 14, 000 nurse prescribers, 1700 pharmacist and supplementary prescribers and many community nurse prescribers and allied health professional prescribers that had qualified to prescribe within their competence. (DOH, London, 2009).

1. 3 . CASE STUDY

This piece of work is acase studyof a service user from the authors practise placement area at the time of writing. The case study incorporates three key elements within it;

The service user

Three medications prescribed to them

The legal and professional issues surrounding the above

The case study will look at these three elements in detail within the report.

2. PATIENT OVERVIEW

(In order to uphold confidentiality, during this report the service user in question will be referred to as ‘ Mary’. (NMC, Code, 2008)

Mary is a seventy three year old lady who was admitted tothe inpatient practise placement area on the 02/04/2011. Mary has a diagnosis of AlzheimersDementiaand was presenting with increased confusion and according to her care givers (Mary was a resident in anursinghome) had been showing signs ofdepressionand aggression over the last few months culminating in a series of aggressive outbursts which ended in a serious attack on a member of her care home staff. The decision had been made that a hospital admission to the organic illness assessment ward (Older people’s services) was necessary to manage risk, assess the progression of Mary’s condition and reassess her package of care. Mary was initially resistant to all interventions from the ward team and displayed high levels of agitation and aggression. The consultant and nursing team felt that medication would play an important role in the management of Mary’s initial presentation. However Mary’s resistance to any therapeutic interventions meant that alternative approaches were felt to be the only option at the start of treatment. John was also given a capacity assessment and found to lack

capacity which allowed the ward staff to treat Mary effectively in her best interests.

(For Mary’s pen story see appendix 1)

3. DIAGNOSIS

Mary has a diagnosis of Alzheimers Dementia.

The Alzheimer’s society explain the term dementia describes a group of symptoms these include a decline in memory, reasoning andcommunicationskills a gradual loss and decline in the skills needed to manage the individuals activities of daily living , confusion and a change in behaviour orpersonality. These symptoms are caused by the physical impact of disease or injury on the brain. There are a number of different conditions that lead to dementia including Alzheimer’s disease.

(http://www. alzheimers. org. uk/site/scripts/documents_info. php? documentID= 160)

3. 1 . DIAGNOSTIC TOOL

“ Making a diagnosis of dementia is often difficult, particularly in the early stages The time it takes to make a diagnosis can vary. If scans and other investigations are required, it could be 4-12 weeks. If the person is in the early stages of dementia, a 6-12 month period of monitoring may be required before a diagnosis can be made.”

(http://www. alzheimers. org. uk/site/scripts/documents_info. php? documentID= 121)

“ The Mini Mental State Examination (MMSE) is the most commonly used test when a diagnosis of Dementia is being considered The MMSE is the test that the National Institute for Health and Clinical Excellence (NICE) recommends for deciding whether a drug treatment for Alzheimers Disease should be prescribed.”

(http://guidance. nice. org. uk/DT)

However NICE dostressit should not be relied on as the only meansof assessment alone as diagnosing dementia involves careful monitoring and assessment.

3. 2. TREATMENT RECCOMENDATIONS

“ Treatment for Dementia should only be initiated and supervised by a specialist experienced in the management of Dementia.” (BNF, 2009, P280)

4. MEDICATION

“ Being prescribed a medicine is arguably the most frequent intervention in the NHS” (Shepherd, 2002).

Mary’s medication was reviewed on admission to the inpatient ward due to her aggressive and volatile presentation. For the purpose of this report three of the medications Mary was prescribed will be discussed in detail.

4. 1. GALANTAMINE

“ Acetylcholinerase inhibiting drugs are used in the treatment of Alzheimers disease, specifically for mild to moderate disease.” (BNF, 2009, P280)

Galantamine is a medication used to treat moderate Alzheimers dementia disease. Alzheimers occurs as a result of atrophy of the cerebral cortex. The disease causes changes in central neurotransmitter function especially the cholinergic system. It is linked to a lack of sufficient acetycholine levels. Evidence also points to raised levels of glutamate (a neurotransmitter).

Galantamine is one of the centrally acting inhibitor of acetylcholinerase. It is a reversible acetylcholinerase inhibitor medication which works by increasing levels of acetylcholinerase in the synaptic cleft of central nervous system neurons. Galantamine is used to ‘ slow’ neuronal degeneration by impeding further atrophy of the cerebal cortex. Evidence for the drug relates to an individual’s cognitive enhancement, however there is no cure for Alzheimers dementia and so medication is purely palliative. (Aarbakke, J et al, 2006)

Interactions of Galantamine from a patient safety perspective include:-

Warfarin effects are enhanced.
Antipsychotics and barbiturates effect is reduced (Johns dose of Zuclopenthixol increased to counteract this)
Muscle relaxants effects are modified.

Dosage of Galantamine must be carefully considered and the individual’s renal functioning and Creatinine levels must be checked prior to treatment.

Side effects of Galantamine include:-

Nausea

Sleep disturbance

Headache

Dizziness

Drowsiness and fatigue

Depression (Treated with Mirtazapine in Mary’s case)

(BNF, 2009, P281)

Mary was prescribed Galantamine Hydrobromide (Reminyl XL) a prolonged release medication. The Scottish medical consortium state Reminyl XL is recommended for the treatment of moderate Alzheimers dementia and allows a reduction in dose frequency and is as cost effective as immediate release forms of Galantamine. (http://www. scottishmedicines. org. uk/files/reminyl_XL_Summary_Advice__FINAL__for_website. pdf)

4. 2. MIRTAZAPINE

Mirtazapine is a medication used to treat depression. Theories explain the cause of depression as a neurobiological change resulting in too little Noradrenaline and 5HT in some central nervous synapses. Mirtazapine is an Atypical antidepressant. It is a presynaptic alpha2 adrenoreceptor antagonist and increases central noradrenergic and serotonergic neurotransmission which then increases the release of noradrenaline. Mirtazapine has an antihistamine effect with sedative effects and so is beneficial to Mary due to

her agitation and restless presentation. Mirtazapine is also suitable for older adults due to its anticholinergic effect. (Aarbakke, J et al, 2006)

Interactions of Mirtazapine from a patient safety perspective include:-

Alcohol – Sedation increased

Warfarin – Enhances anticoagulant effect

Anxiolytics and hypnotics – Sedation increased. Mary is also prescribed Lorazepam at present and this is monitored closely when given for over sedation.

Withdrawl from Mirtazapine must be staggered due to side effects of withdrawing. (http://www. medicinenet. com/mirtazapine/article. htm)

Dosage – Mary is on a titrating dose of Mirtazapine and so may be experiencing side effects which she is not used to and may cause her further distress. It was important that Mary be monitored closely and reassured during this time.

Side effects of Mirtazapine include:-

Increased appetite and weight gain (regular weight assessed and diet chart commenced)

Oedema

Sedation (Mary is monitored closely for over sedation due to her other medications sedative effects)

Dizziness and headache

Postural hypotension (Mary’s blood pressure is checked daily)

“ Mirtazapine causes few antimuscarinic effects and is therefore recommended over Trycyclic antidepressants” (BNF, 2009, P215).

4. 3. LORAZEPAM

Lorazepam is an Anxiolytic. Benzodiazepine anxiolytics are indicated for use short-term inanxietystates. However they are also used as an adjunctive therapy at the beginning of anti-depressant treatment to ease the initial worsening of symptoms, as in Mary’s case.

Interactions of Lorazepam from a patient safety perspective:-

Respiratory Depression- (Mary was monitored and physical obs taken post dose)

Sleep apnoea syndrome (Mary was on arms lengthobservationlevels anyway)

Severe hepatic impairment

Myasthenia Gravis

Side effects of Lorazepam include:-

Drowsiness

Lightheadedness

Confusion

Ataxia

Headache

Hypotension (Mary’s bp was taken on a daily basis)

Confusion and Ataxia may be particularly apparent in elderly and should be closely monitored. (BNF, 2009, P189)

5. LEGAL, ETHICAL AND PROFESSIONAL ISSUES

Therapeutic interventions which involve the prescribing and administration of medications have legal, professional and ethical implications. In Mary's case these included the following issues.

5. 1. ADHERENCE

One of the problems with medication administration as part of planned care was Mary's resistance to all interventions from the ward staff.

" People with dementia often have problems taking prescribed medication. They may forget to take it without prompting or supervision, and can lack awareness of their health problems. Some believe they do not need medication as they think there is nothing wrong with them." (Stapleton, L. 2010)

Medication adherence can be improved by applying some simple measures:-

Ensure patients know what drugs they are taking, why they are taking them, and when. Also check that they are aware of any possible side effects, and what to do if they experience them.

Check that all patients with dementia are able to take their medication safely by organising dosette systems, and ensure carers can help patients where necessary.

Give all patients and their families' information about how to contact the

clinic nurse by providing verbal information and written leaflets.

Ensure patients have a written treatment plan.

(Stapleton, L. 2010)

According to Cheesman (2006), adherence is an approach to achieving the best use of medication involving the sharing of information between healthcare professionals and patients. The prescriber can promote an effective therapeutic relationship by building a patient's confidence in their ability to self-manage their condition.

5. 2. MENTAL CAPACITY

" The Mental Capacity Act 2005 provides a statutory framework to empower and protect people aged 16 and over who lack, or may lack, capacity to make certain decisions for themselves because of illness, a learning disability, or mental health problems. The act was fully implemented in October 2007 and applies in England and Wales. If someone is unable to make a decision for themselves at the material time because of an impairment of the mind, then that person can be said to lack the mental capacity to make that decision."(Alzheimers society, 2011).

According to the law, a person is defined as being unable to make decisions for themselves if they are not able to undertake at least one of the following:

understand information given to them

retain that information long enough to be able to make a decision

weigh up the information available to make a decision

communicate their decision by any possible means, including talking, using sign language, or even through simple muscle movements such as blinking an eye or squeezing a hand. (Rethink, 2010)

Mary was found to lack capacity as she was unable to retain or weigh up the information given to him to make a decision. Mary lacked any insight into her recent worsening of symptoms, changes in behaviour and aggression. This is often the case with dementia disease.

“ The act encompasses five main principles:

1 A presumption of capacity ? Every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2 The right for individuals to be supported to make their own decisions ? All reasonable help and support should be provided to make their own decisions.
3 It should not be assumed that someone lacks capacity simply because their decisions might seem unwise or eccentric.
4 If someone lacks capacity, anything done on their behalf must be done in their best interests.
5 If someone lacks capacity, before making a decision on their behalf, all alternatives must be considered and the option chosen should be the least restrictive of their basic rights and freedoms.” (Warren, L. 2010)

“ When considering a person’s views and wishes it is important that they are given weight, and are carried out, unless the effects would be detrimental to that person.”(National archives, 2010)

The multi-disciplinary team worked to all these principles in Mary’s case by:-

1. Presuming capacity by letting Mary make decisions until the capacity assessment had been done and a formal plan of care put in place. Mary was also supported to continue to make decisions on a daily basis which she was deemed to have capacity to make e. g. what to wear that day.
2. Support was provided in the form of an Independent mental health advocate (IMHA).
3. Mary was found to have capacity to makecertaindecisions even if theyseemed strangeto the ward staff. Staff supported her in this.
4. Mary had a best interest assessment and the findings were used to formulate a comprehensive care plan for Mary.
5. The MDT sought input from the deprivation of liberty safeguarding team (DOLS) around the intervention decisions with Mary to ensure they were applying the least restrictive care.

5. 3. ETHICAL CONCERNS

When working with people with dementia ethical practise should be considered as dementia is a long-term illness with no cure. Treatment is purely palliative and the evidence for the benefit versus drawbacks to treatment is not fully understood. (www. mind. org. uk)

Foot Anstey solicitors explain that Advance directives and lasting power of attorneys put in place can ensure that the service user receives the treatment and care they want when they are no longer able to voice their requirementsthemselves. (www. repod. org. uk)

Healthcare professionals must make the service user the centre of care decisions in the service user's best interests to uphold ethical practise.

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