Medicines optimisation

NICE quality standard

Draft for consultation

October 2015

Introduction

This quality standard covers the safe and effective use of medicines in health and social care settings for all people who take medicines, and people who are receiving suboptimal benefit from medicines.

It does not cover aspects of managing medicines specific to care home settings because this is covered by another quality standard. For more information see the topic overview.

Why this quality standard is needed

Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'. Medicines optimisation applies to people who may or may not take their medicines effectively.

Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines. Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare. However, it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended (World Health Organization 2003). This issue is worsened by the growing number of people with long-term conditions. In 2012, the Department of Health published Long-term conditions compendium of information: third edition which suggested that about 15 million people in England now have a long-term condition and the number of long-term conditions a person may have also increases with age: 14% of people under 40 and 58% of people over 60 report having at least 1 long-term condition. The report

defines a long-term condition as 'a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies'. When 1 or more non-curable long-term conditions are diagnosed, this is termed 'multimorbidity'. The number of people with multimorbidity in 2008 was 1.9 million, but this is expected to rise to 2.9 million by 2018. Twenty-five per cent of people aged over 60 report having 2 or more long-term conditions.

Data from the Health and Social Care Information Centre (HSCIC) shows that between 2003 and 2013 the average number of prescription items per year for every person in England increased from 13 to 19. With an ageing population, the use of multiple medicines (polypharmacy) is increasing.

The quality standard is expected to contribute to improvements in the following outcomes:

- quality of life for people with long-term conditions
- reduce mortality
- increase life-expectancy for people with long-term conditions.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult Social Care Outcomes Framework 2015–16
- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* ***Outcome measures*** **People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life.** 1D Carer-reported quality of life
Aligning across the health and care system * Indicator complementary ** Indicator shared	

Table 2 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1b Life expectancy at 75 i Males ii Females
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*, ** **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers**

	Enhancing quality of life for people with mental illness 2.5 i Employment of people with mental illness** *ii Health-related quality of life for people with mental illness*** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare* ***Improvement areas*** **Reducing the incidence of avoidable harm** **Improving the culture of safety reporting** 5.6 Patient safety incidents reported
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 Public Health Outcomes Framework for England, 2013–16

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.3 Mortality rate from causes considered preventable** 4.11 Emergency readmissions within 30 days of discharge from hospital* 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to medicines optimisation.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services, which should be considered alongside this quality standard. It specifies that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. It also covers the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for medicines optimisation specifies that services should be commissioned from and coordinated across all relevant agencies that are involved in prescribing, dispensing and administering medicines. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people who take medicines in health and social care settings.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality medicines optimisation service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people who take medicines in health and social care settings should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people who are taking medicines in health and social care settings. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. People have the opportunity to be involved in making decisions about their medicines.

Statement 2. Health and social care providers monitor reported medicines-related patient safety incidents to inform cross-sector action and best practice in the use of medicines.

Statement 3. People who take medicines receive information on how to identify and report medicines-related patient safety incidents.

Statement 4. People admitted to an acute setting, or transferred within acute settings, have a reconciled list of their medicines within 24 hours.

Statement 5. People discharged from an acute care setting to primary care have their medicines documented in the discharge summary and reconciled in the GP list within 1 week of the GP practice receiving the information.

Statement 6. People taking multiple medicines or taking medicines for long-term conditions have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Statement 7. Health and social care providers adopt a multidisciplinary approach to communicating complete and accurate information about the use of a person's medicines when people move between care settings.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers?

Quality statement 1: Shared decision-making

Quality statement

People have the opportunity to be involved in making decisions about their medicines.

Rationale

People should be able to have an active role in their own healthcare, and to be involved in making decisions about the medicines that they take. This may include decisions not to take specific medicines. Healthcare professionals can use patient decision aids to support a shared decision-making approach in a consultation, to ensure that patients, and their family members or carers (where appropriate), are able to make well-informed choices that are consistent with their individual values and preferences.

Quality measures

Structure

Evidence of local arrangements to ensure that people have the opportunity to be involved in making decisions about their medicines.

Data source: Local data collection.

Outcome

a) Patient medication adherence rates.

Data source: Local data collection.

b) Patient satisfaction rates.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as primary, secondary and tertiary care) ensure that people have the opportunity to be involved in making decisions about their medicines.

Healthcare and social care practitioners ensure that people have the opportunity to be involved in making decisions about their medicines.

Commissioners (such as NHS England and clinical commissioning groups) ensure they commission services in which people have the opportunity to be involved in making decisions about their medicines.

What the quality statement means for patients, service users and carers

People who take medicines and those who choose not to have the opportunity to be involved in making decisions about their medicines in line with their values and preferences.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.6.1 and 1.6.2

Definitions of terms used in this quality statement

Involved in making decisions

Health and social care practitioners should find out about a person's values and preferences by discussing what is important to them about treating or managing their condition(s) and their medicines. They should ask open questions to understand the patient’s ideas, concerns and expectations. This process can he helped by the use of patient decision aids. It is important to recognise that the person’s values and preferences may be different from those of the health and social care practitioner and that making assumptions about these should be avoided. [Medicines

optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.6.2 and full guideline]

Equality and diversity considerations

People who are offered or prescribed medicines may have different values and preferences that affect their choices about the use of medicines. Health and social care practitioners should ensure that all people are able to express their preferences, and are able to take part in shared decision-making about the use of medicines. Health and social care practitioners should recognise that a person's preferences may differ from their own, and take part in shared decision-making in a sensitive and supportive way. When people need additional support in communicating their preferences, for example because English is not their first language or if they have sensory difficulties, these should be taken into account by health and social care practitioners.

Quality statement 2: Learning from medicines-related patient safety incidents

Quality statement

Health and social care providers monitor reported medicines-related patient safety incidents to inform cross-sector action and best practice in the use of medicines.

Rationale

Monitoring reported medicines-related patient safety incidents can help identify trends and causes of incidents. Learning from incident reporting, and sharing the outcome of learning among providers across local care settings, can lead to effective action, such as setting up computer alerts and staff training. This can help to minimise the risk of medicines-related patient safety incidents and produce better outcomes for people who take medicines.

Quality measures

Structure

Evidence of local arrangements to ensure that health and social care providers monitor reported medicines-related patient safety incidents to inform cross-sector action and best practice in the use of medicines.

Data source: Local data collection

Process

Proportion of reviewed medicines-related patient safety incidents.

Numerator – the number in the denominator that are reviewed.

Denominator – the number of reported medicines-related patient safety incidents.

Data source: Local data collection.

Outcome

Number of reported medicines-related patient safety incidents.

Data source: Local data collection, Medicines Optimisation Dashboard and National Reporting and Learning System.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as primary, secondary and tertiary care, community care and social care) ensure that they monitor reported medicines-related patient safety incidents to inform cross-sector action and learning, to ensure best practice and safety in the use of medicines.

Health and social care practitioners contribute to the reporting and monitoring of medicines-related patient safety incidents, and collaborate in cross-sector action and learning, to ensure best practice and safety in the use of medicines.

Commissioners (such as NHS England, clinical commissioning groups and local authorities) ensure that they commission services from healthcare providers that monitor reported medicines-related patient safety incidents to inform cross-sector action and learning, to ensure best practice and safety in the use of medicines.

What the quality statement means for patients, service users and carers

People who take medicines are cared for by healthcare providers who monitor reported medicines-related patient safety incidents and take action and share learning with other local care providers to ensure best practice and safety in the use of medicines.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendations 1.1.3, 1.1.5 and 1.1.11.

Definitions of terms used in this quality statement

Medicines-related patient safety incidents

Medicines-related patient safety incidents are unintended or unexpected incidents that were specifically related to medicines use, which could have, or did, lead to patient harm. These include:

- potentially avoidable medicines-related hospital admissions and re-admissions
- prescribing errors
- dispensing errors
- administration errors
- monitoring errors
- potentially avoidable adverse events
- missed doses of medicines
- near misses (a prevented medicines-related patient safety incident which could have led to patient harm).

Medicines-related patient safety incidents do not include expected medicines side effects. [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.1.3 and expert opinion]

Quality statement 3: Patient involvement in reporting medicines-related patient safety incidents

Quality statement

People who take medicines receive information on how to identify and report medicines-related patient safety incidents.

Rationale

Reporting on and learning from medicines-related patient safety incidents can be more effective if it is informed by the people who take medicines. People need to understand their medicines and the issue of medicines-related patient safety incidents (as opposed to expected side-effects of using medicines). Patient involvement can increase the number of incidents reported through better identification, and aid learning by organisations and health and social care practitioners responsible for the optimisation of medicines.

Quality measures

Structure

Evidence of local arrangements to ensure that people who take medicines receive information on how to identify and report medicines-related patient safety incidents.

Data source: Local data collection.

Outcome

The number of medicines-related patient safety incidents.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as health and social care) ensure that systems are in place for people who take medicines to receive information on how to identify and report medicines-related patient safety incidents.

Health and social care practitioners ensure that they provide information to people who take medicines on how to identify and report medicines-related patient safety incidents.

Commissioners (such as NHS England, clinical commissioning groups and local authorities) ensure that they commission services that make sure people who take medicines receive information on how to identify and report medicines-related patient safety incidents.

What the quality statement means for patients, service users and carers

People who take medicines in health and social care settings receive information on how to recognise and report medicines-related patient safety incidents, and on who they can ask for help.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.1.6

Definitions of terms used in this quality statement.

Medicines-related patient safety incidents

Medicines-related patient safety incidents are unintended or unexpected incidents that were specifically related to medicines use, which could have, or did, lead to patient harm. These include:

- potentially avoidable medicines-related hospital admissions and re-admissions
- prescribing errors
- dispensing errors
- administration errors
- monitoring errors
- potentially avoidable adverse events
- missed doses of medicines
- near misses (a prevented medicines-related patient safety incident which could have led to patient harm).

Medicines-related patient safety incidents do not include expected medicines side effects. [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, section 1.1 and expert opinion]

Equality and diversity considerations

Health and social care practitioners should recognise that people's ability to understand the issue of medicines-related patient safety incidents may differ, and therefore that the issue should be communicated effectively. When patients need additional support to understand the issue, for example because English is not their first language or if they have sensory difficulties, these should be taken into account by health and social care practitioners.

Quality statement 4: Medicines reconciliation in acute settings

Quality statement

People admitted to an acute setting, or transferred within acute settings, have a reconciled list of their medicines within 24 hours.

Rationale

Medicines-related errors and adverse events are more likely to occur when medicines reconciliation happens too late following an acute admission or transfer. Undertaking medicines reconciliation within 24 hours of an acute setting admission or transfer will enable early action to be taken when discrepancies between lists of medicines are identified.

Quality measures

Structure

Evidence of local arrangements to ensure that a person has a reconciled list of their medicines within 24 hours of being admitted to an acute setting or transferred within acute settings.

Data source: Local data collection and Medicines Optimisation Dashboard.

Process

a) Proportion of people in an acute setting who have a reconciled list of their medicines within 24 hours of admission.

Numerator – the number in the denominator who have a reconciled list of their medicines within 24 hours.

Denominator – the number of people who are admitted to an acute setting.

Data source: Local data collection.

b) Proportion of people transferred within acute settings who have a reconciled list of their medicines within 24 hours of transfer.

Numerator – the number in the denominator who have a reconciled list of their medicines within 24 hours.

Denominator – the number of people who are transferred within acute settings.

Data source: Local data collection.

Outcome

Reduction of medicines-related patient safety incidents.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as secondary care and mental health providers) ensure that systems are in place for people who are admitted to an acute setting or transferred within acute settings to have a reconciled list of their medicines within 24 hours.

Healthcare professionals (such as doctors, nurses, pharmacists and pharmacist technicians) ensure that they reconcile a person's medicines within 24 hours of an admission to an acute setting or transfer within acute settings.

Commissioners (such as NHS England and clinical commissioning groups) ensure that they commission services that ensure that medicines are reconciled within 24 hours of a person's admission to an acute setting or transfer within acute settings.

What the quality statement means for patients, service users and carers

People who take medicines have an up-to-date list of their medicines within 24 hours of entering the acute setting or being moved within acute settings. They may be involved in the reconciliation process if they wish to do so. This ensures that any discrepancies with their medicines are quickly noticed and resolved.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.3.1 and 1.3.5

Definitions of terms used in this quality statement

Acute care settings

Acute care settings include secondary care, tertiary care and mental health. [Expert opinion]

Reconciled list

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated and addressing any issues with the medicines such as wrong dosage or omission. [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5 and expert opinion]

Equality and diversity considerations

Health and social care practitioners should recognise that people's ability to understand the issue of medicines reconciliation may differ, and therefore that the issue should be communicated effectively. When people need additional support to understand the issue, for example because English is not their first language or if they have sensory difficulties, these should be taken into account by health and social care practitioners.

Quality statement 5: Medicines reconciliation in primary care

Quality statement

People discharged from an acute care setting to primary care have their medicines documented in the discharge summary and reconciled in the GP list within 1 week of the GP practice receiving the information.

Rationale

Medicines-related patient safety incidents are more likely to occur when medicines reconciliation happens too late after a discharge from an acute setting to primary care. Undertaking medicines reconciliation in primary care within 1 week of receiving discharge information will mean that early action can be taken when discrepancies between lists of medicines are identified. For example, it can prevent people from being prescribed medicines that were stopped while they were in hospital.

Quality measures

Structure

Evidence of local arrangements to ensure that medicines are documented in the discharge summary and reconciled in the GP list within 1 week of the GP practice receiving the information, for all people who have been discharged from an acute care setting.

Data source: Local data collection.

Process

The proportion of people discharged from an acute care setting to primary care who have their medicines documented in the discharge summary and reconciled in the GP list within 1 week of the GP practice receiving the information.

Numerator – the number in the denominator who have their medicines documented in the discharge summary and reconciled in the GP list within 1 week of the GP practice receiving the information.

Denominator – the number of people on medication who are discharged from an acute care setting to primary care.

Data source: Local data collection.

Outcome

Reduction of medicines-related patient safety incidents.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as acute units, mental health providers and GP practices) ensure that systems are in place for people who are discharged from an acute care setting to have their medicines documented in the discharge summary and reconciled in the GP list within 1 week of the GP practice receiving the information.

Healthcare professionals (such as consultant, nurse, GPs, pharmacists and practice nurses) ensure that they document medicines in the discharge summary and reconcile this in the GP list within 1 week of the GP practice receiving the information.

Commissioners (such as NHS England and clinical commissioning groups) ensure that they commission services which document medicines in the discharge summary and reconcile this with the GP list within 1 week of the GP practice receiving the information.

What the quality statement means for patients, service users and carers

People who take medicines who are discharged from an acute care setting have their medicines documented in the discharge summary and reconciled in the GP list within 1 week of the information reaching the GP practice. They may be involved in the reconciliation process if they wish to do so. This means that any discrepancies with their medicines are quickly noticed and resolved.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.3.3 and 1.3.5

Definitions of terms used in this quality statement

Acute care settings

Acute care settings include secondary care, tertiary care and mental health. [Expert opinion]

Reconciled in the GP list

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated and addressing any issues with the medicines such as wrong dosage or omission. [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5 and expert opinion]

Equality and diversity considerations

Health and social care practitioners should recognise that people’s ability to understand the issue of medicines reconciliation may differ, and therefore that the issue should be communicated effectively. When people need additional support to understand the issue, for example because English is not their first language or if they have sensory difficulties, these should be taken into account by health and social care practitioners.

Quality statement 6: Medication review

Quality statement

People taking multiple medicines or taking medicines for long-term conditions have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Rationale

A structured medication review, with the clear purpose of optimising the use of medicines for specific people (such as those who have long-term conditions or who take multiple medicines), can identify medicines that could be stopped or need a dosage change. An example of this is medicines that were prescribed a long time ago and are no longer needed or need to be changed to a different formulation. This can lead to a reduction in adverse effects. A medication review can also identify the need for the prescription of new medicines.

Quality measures

Structure

a) Evidence of local arrangements and written protocols to ensure that people taking multiple medicines have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Data source: Local data collection.

b) Evidence of local arrangements and written protocols to ensure that people taking medicines for long-term conditions have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Data source: Local data collection.

Process

a) Proportion of people taking multiple medicines who have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Numerator – the number in the denominator who have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Denominator – the number of people taking multiple medicines

b) Proportion of people taking medicines for long-term conditions who have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Numerator – the number in the denominator who have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Denominator – the number of people taking medicines for long-term conditions.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as GP practices) ensure that systems are in place for people taking multiple medicines or taking medicines for long-term conditions to have a discussion with their healthcare professional about the need for and purpose of a structured medication review.

Healthcare professionals (such as GPs and pharmacists) ensure that they have a discussion with the person taking multiple medicines or taking medicines for long term conditions about the need for and purpose of a structured medication review. Where the need and purpose is identified, the structured medication review will take place.

Commissioners (such as NHS England and clinical commissioning groups) ensure that they commission services that make sure they provide a discussion between their healthcare professional and the person on multiple medicines or taking medicines for long-term conditions about the need for and purpose of a structured medication review. Where the need and purpose is identified, the structured medication review will take place.

What the quality statement means for patients, service users and carers

People who take medicines have a discussion with their healthcare professional about the need for and purpose of a structured medication review. This could be, for example, if they use more than 1 medicine or medicines for long-term conditions. Where the need and purpose is identified, the structured medication review will take place. This can help to identify any medicines they no longer need or if they need a dosage change.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendation 1.4.1, 1.4.2 and 1.4.3

Definitions of terms used in this quality statement

Medication review

A medication review is a structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste. [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5]

Equality and diversity considerations

Healthcare professionals should recognise that people's ability to understand the importance of medication reviews may differ, and ensure that people are supported to understand the purpose and benefits of a structured medication review. When people need additional support to understand the issue, for example because English is not their first language or if they have sensory difficulties, these should be taken into account by healthcare professionals.

Quality statement 7: Multidisciplinary working

Quality statement

Health and social care providers adopt a multidisciplinary approach to communicating complete and accurate information about the use of a person's medicines when people move between care settings.

Rationale

People taking medicines can have complex needs, and their care may be provided by healthcare professionals working in different care settings. When people move between settings there needs to be a collaborative approach to their care. Effective cross-sector working, and sharing of complete and accurate information, between healthcare professionals across all sectors, can ensure that people who take medicines benefit from a coordinated approach to their care.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that health and social care providers adopt a multidisciplinary approach to communicating complete and accurate information about the use of a person's medicine when people move between care settings.

Data source: Local data collection.

Outcome

Reduction of medicines-related patient safety incidents when the person moves between care settings.

Data source: Local data collection and medicines optimisation dashboard.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (health and social care providers) ensure that systems are in place for adopting a multidisciplinary approach to communicating complete and

accurate information about the use of a person's medicines when people move between care settings.

Health and social care practitioners ensure that they have a multidisciplinary approach to communicating complete and accurate information about the use of a person's medicines when people move between care settings.

Commissioners (such as NHS England and clinical commissioning groups) ensure that they commission services that adopt a multidisciplinary approach to communicating complete and accurate information about the use of a person's medicines when people move between care settings.

What the quality statement means for patients, service users and carers

People who take medicines are cared for by providers that adopt a multidisciplinary approach to communicating complete and accurate information about the use of a person's medicines when they move between care settings. This encourages better communication and exchange of information which can contribute to the person getting the most out of their medicines.

Source guidance

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5, recommendations1.2.1, 1.2.2, 1.2.5 and 1.8.1

Definitions of terms used in this quality statement

Multidisciplinary approach

This involves all health and social care professionals who take part in a person's care to exchange information, including the health and social care organisations as well as health and social care professionals. [Expert opinion]

Status of this quality standard

This is the draft quality standard released for consultation from 5th October to 2nd November 2015. It is not NICE's final quality standard on medicines optimisation. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 2nd November 2015. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from March 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources [Link to section in web version] and NICE's cancer service guidance on improving outcomes in medicines optimisation and the National Cancer Peer Review Programme's Manual for cancer services: medicines optimisation.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments [add correct link] are available.

Good communication between health, public health and social care practitioners and people who are taking medicines in health and social care settings, and their families or carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People who are taking medicines in health and social care settings and their families or carers (if appropriate) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Public Health England (2015) Behaviour change and antibiotic prescribing in healthcare settings: literature review and behavioural analysis
- NHS England (2014) Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices
- Care Quality Commission (2013) The safer management of controlled drugs
- General Medical Council (2013) Good practice in prescribing and managing medicines and devices
- King's Fund (2013) Polypharmacy and medicines optimisation: making it safe and sound
- NHS England (2013) Workshop report: Making medicines-taking a better experience
- Public Health England (2013) Antimicrobial prescribing and stewardship competencies
- Royal College of Nursing (2013) Better medicines management: advice for nursing staff and patients
- Royal Pharmaceutical Society (2013) Medicines optimisation: helping patients to make the most of medicines

- Department of Health (2012) Improving the use of medicines for better outcomes and reduced waste: an action plan
- Department of Health (2011) Impact assessment on the introduction of the new medicine service
- Department of Health (2011) Making best use of medicines: report of a Department of Health roundtable event hosted by The King's Fund
- Department of Health (2010) Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing

Definitions and data sources for the quality measures

Primary source

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (2015) NICE guideline NG5

Related NICE quality standards

Published

- Drug allergy: diagnosis and management (2015) NICE quality standard 97
- Managing medicines in care homes (2015) NICE quality standard 85
- Patient experience in adult NHS services (2012) NICE quality standard 15

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Antimicrobial stewardship: changing risk-related behaviours in the general population
- Medicines management: managing the use of medicines in community settings for people receiving social care

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee is as follows:

Miss Alison Allam
Lay member

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The following specialist members joined the committee to develop this quality standard:

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GP and Medical Advisor in Therapeutics, Aneurin Bevan University Health Board

Mr Richard Seal

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on medicines optimisation.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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