An Audit of Medication Review Practices in Prisons

Patients detained in the Health and Justice estate should receive healthcare that is equivalent to what they could expect to receive in the community. As with other settings, a prescribed medicine is the most common patient-level intervention that people receive [1]. The regular and effective review of a person's medicines is essential to ensuring an individual receives safe, effective and appropriate care. Medicines review is also a key tool used to identify and tackle overprescribing. Guidance on the review of medicines has evolved recently in line with the NHS Long Term Plan and the National Overprescribing Review [2]. The implementation of Structured Medication Reviews (SMRs) in Health and Justice settings shows that this continues to evolve. An audit was undertaken to assess how current medicines review practices in North East and Yorkshire prisons meet the needs of patients detained.

Method

An audit was developed using relevant guidance such as the NICE guidance,[3,4] professional guidance [5,6] and relevant the service specifications [7]. Interviews were conducted with regional-level pharmacy teams for provider organisations and then site-visits were conducted across 10 prison sites. The prisons visited included the male and female estate and all security categories (A-D-open) and a Young Offenders Institute (YOI). On each site visit, alongside the audit, a sample of patient records of patients who were prescribed a dependence forming medication were reviewed to assess the medicines reviews undertaken.

Results

- **20%** of sites were currently delivering (SMRs) and these had pharmacist involvement in these.
- There was variation in who delivered medication reviews with GPs, nurses, Advanced Clinical Practitioners (ACPs), pharmacists and mental health teams completing these, depending on the medications.
- **40%** of sites provided other routine pharmacist-led medication review clinics.
- **10%** of sites had regular Learning Disability STOMP/STAMP clinics led by a psychiatrist.

Following a review of medication review records:

- Not all patients prescribed a dependence forming medication had received a medication review in line with the 6 or 12 month standard.
- Multidisciplinary team (MDT) medication reviews were common for complex prescribing however these were not always readcoded as medication reviews on clinical records.
- The medication review readcode was not always used.

Discussion and Conclusion

Audits were completed and the results compiled to assess whether current practices were meeting the required standards. Sites received individual action plans to help them achieve compliance with standards. Recommendations were also made to regional pharmacy teams to enable them to deliver any of the more strategic changes required. Plans were made to assess progress on the action plans and re-audit medication review practices in the future.

References

1. *Prescribed medicines - NHS England Digital*
2. *National overprescribing review report - GOV.UK*
3. *NICE Guidance CG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes*
4. *Overview | Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence | Guidance | NICE*
5. *Royal College of General Practitioners (January 2019) Safer Prescribing in Prisons. Guidance for clinicians*
6. *RCGP/RPS Repeat Prescribing Toolkit https://www.rpharms.com/resources/repeat-prescribing-toolkit*
7. *Health and Justice mental health services: Safer use of mental health medicines*

Author

James Ledger, Senior Medicines Optimisation Pharmacist, NECS

Acknowledgement

Nicola Ellis, Senior Quality Manager, NHSE NEY Health & Justice (Yorkshire and the Humber)

Contact

james.ledger2@nhs.net