THE UNIVERSITY OF WESTERN AUSTRALIA

'Seniors have a say in research on medication safety'

Prepared for Consumers Health Forum of Australia for discussion at the National Medicines Policy Meeting June 2010

Background

The University of Western Australia's School of Population Health and the School of Primary, Aboriginal and Rural Health Care have undertaken a research project funded by the NHMRC on medication safety in seniors (65+). The project which has been led by Professors D'Arcy Holman and Jon Emery is currently in the reporting phase. The project used Commonwealth PBS and MBS data linked to Western Australian hospital separations and death registration to investigate the burden of unplanned hospital stays caused by adverse drug reactions.

The research includes a structured and substantial component of consumer participation. This included three community forums to discuss medication safety issues in older people and then the establishment of a Seniors Consumer Panel. The Panel which is composed of 10 seniors, who have a range of chronic health issues and take multiple medications, has provided ongoing advice to the researchers for the duration of the project. The resources devoted to consumer participation in this research are higher than average and has maintained the level of participation at a consistently strong level.

There is a wealth of important information on consumer perspectives that is emerging from these participative activities, many of which were unexpected. Following are two main issues where the Seniors Panel has made suggestions that we believe are of sufficient importance to advocate for change.

Cease the use of non-informative and abbreviated dose instructions

The Panel recommended that dosing instructions such as:

- 'Take as directed by Dr' or 'Take as directed when required'; and
- Use of Latin abbreviations such as 'bd', 'qid', and so on is strongly discouraged and eventually defined as unacceptable and unsafe practice.

The Panel considers instructions like this could in fact be a major contributor to adverse drug reactions in seniors. Often seniors may be taking multiple medications and may not always remember or misunderstand the doctor's verbal instructions given during a brief consultation where numerous issues are discussed. In addition, seniors may be unable to recall and relay appropriate information to caregivers. This may also have financial implications if people are being hospitalised for adverse medicine events due to this practice.

Since the original issue was raised by the panel the following points have also been put forward by other health consumers and researchers:

- The use of non-specific dosing instructions for medicines would not be considered acceptable practice in hospitals, for example a Dr would not write in patient notes 'take as directed by the Dr ' and expect that a nurse or patient would just remember what instructions had been given.
- This practice also has serious safety issues for a patient presenting to a hospital emergency department (particularly after-hours) with medicines that have non-specific instructions on them. This could be especially difficult if the person is not able to give reliable information on dosages.

In August 2009, Norman Swan interviewed panel members about this issue for the ABC Health Report. Since then they have had contact from health consumers and health professionals from all over Australia who are equally concerned about this practice. During 2009 /10 we have written to or contacted organisations such as the NPS, the AMA, the Pharmacy Guild, the TGA, the Commission on Safety and Quality, Consumers Health Forum, the Federal Minister for Health, RACGP, Western Australian Therapeutic Advisory Group, WA Department of Health, the Department of Health and Ageing and Consumers Health Forum seeking their support to discourage the use of non-specific dosing instructions on prescription medicines. We also hosted a meeting of state-based stakeholders from these organisations in December 2009 to further discuss ways to cease this practice. At this meeting we

were informed that CHF had been involved in previous consumer research on this subject and published an article titled *'Take as Directed whatever that means'* in 2000. These issues have been raised during conference presentations during the same period.

A decade late this issue continues to be unresolved and is still being raised by health consumers as a major safety and quality issue.

Develop a system of stickers to show which part of the body the medicine is for
The second major issue raised by the Panel was about prescription medicine packaging. The Panel advised that many older Australians think about their medicines in terms of target organs or diseases; 'my heart medicine'; 'my stomach medicine', 'my diabetes medicine', 'my blood pressure medicine' and believes that this conceptual framework is an underused resource that can be tapped into to improve medication safety. If pharmacists were to apply stickers with graphical 'symbols' for the major body organs and some common generalised diseases, this would assist patients with multiple medications to avoid confusion with dose regimes as well as adherence to treatment.

The Panel has also offered a number of other points about medicine pack information, which we list as follows:

- The minimum font size should be 12 point;
- The active ingredient should always be used first on labels. The use of different names for the same medication; e.g. brand name and generic name is very confusing to patients and can cause double dosing of the same medicine;
- Space for subsidised price information on label stickers would be better used to improve dosing information;
- Major side effects or interactions should always be shown;
- Include "last repeat" on the label when appropriate to alert patients that they need a new script;
- Pharmacists should avoid accidentally covering use-by dates with stickers; and
- Include stickers (or graphics) to show the part of the body the medicine is intended for.

Other key issues raised by seniors:

- Lack of consistency in access to CMI – seniors preferred system when they automatically came in the packaging;
- Lack of knowledge of Home Medicine Reviews (only 4 of the 104 people who attended the seniors forums had heard of or had a HMR);
- Seniors reported breaking or dividing medicines without seeking advice when dosage gives unpleasant side effects.
- Pressure to switch to a generic medicine by the pharmacist when this had not been discussed by the prescribing doctor. Seniors preferred to pay more for a branded medicine they were familiar with; and
- Lack of knowledge about credible medicine information sources.

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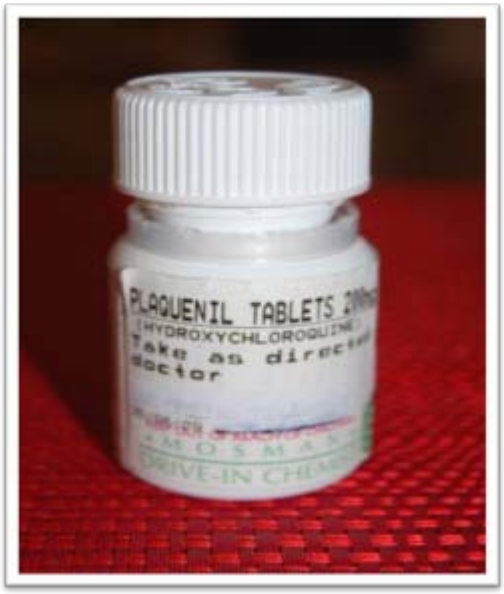
Brand confusion – person took both medicines not realising they were the same medicine

Non specific dosing instructions – unsafe practice



Good practice examples of the use of graphics or stickers