



Good medicines management: From describing problems to a vision for change

Good medicines management is a cornerstone of high-quality palliative care. Any prescribing decision commences a cascade of formal and informal work to enact and link tasks (in the multi-step process of medicines management), people (professionals, patients and carers) and places (home, hospital, care home and hospice). All steps – assessment, prescribing, supply and access, use and administration, review, deprescribing and disposal – present opportunities to prioritise the patient's perspective and needs, and with their permission, that of their families.

Poor medicines management is a major contributor to serious incidents in palliative care. Effective palliation can be disrupted by untimely prescribing, unavailability of medicines or professionals for administration, incorrect opioid selection or conversion of doses, ineffective set-up and use of syringe pumps, and failure of continuity as patients move between care settings.¹

When discussing medicines management, patients, carers and healthcare professionals share common narratives of 'concern', 'pressure', 'fear', 'feeling uncomfortable', 'feeling scared', 'anxiety', 'burden', 'challenge' and 'strain'.^{2–5} The worry and concern of hastening death and being responsible for 'the last injection' is expressed by both family carers and nursing staff who administer anticipatory medications.^{2,4} Clinicians also fear medication changes will be interpreted as 'giving up on the patient' and worry about resistance from patients and families to deprescribing.⁶

Key questions are 'who does what and when?' and 'how can they be best supported?'. Challenges are not simply about practical task allocation, but hold significance in terms of (perceived) responsibilities for potential consequences. For example, medicines management work of carers when someone is seriously ill and dying at home is enormous, spanning administrative, physical, emotional and knowledge aspects of care.⁵ Related tasks such as liaising with healthcare professionals, attending appointments and obtaining medicines supplies all contribute to carers feeling continuously 'on call'. Carers feel expected to have a pivotal role in understanding medication, developing systems for use and administration at home, and providing feedback to healthcare

professionals across settings. Medication-related work with limited knowledge and information is a source of strain,⁵ with language and literacy needs requiring detailed consideration.⁷

When multiple prescribers are involved in one person's care, it can be unclear who has overall professional responsibility for prescribing, deprescribing and medication rationalisation. This can lead to the patient experiencing polypharmacy and poor quality of care.⁷ It can also lead to carers worrying about their abilities to understand and record changes in order to synchronise professionals and avoid future problems.³ System support to coordinate medication management among professionals and allocate lead responsibility can improve effective collaboration between professionals, patients and carers, and ultimately outcomes.⁶

Community and out-of-hours services are particularly susceptible to being disjointed, poorly coordinated, and inconsistent in providing personnel, medication or equipment when needed.¹ Pharmacists report having problems with access to clinical services, medicines, medicines-information and patient medical records.⁷ Delays in prescribing, supply of medication from pharmacies and delivery of medicines are common.⁸ This is especially concerning given the increasing trend to care for the dying outside of hospitals.

A whole system wide approach, allowing for transitions between hospital, hospice and community settings, that recognises all elements of each step in medicines management processes is needed. Teasing out the nuances of needs and wants of medication-related care requires time and collaboration. We know pockets of effective management exist,⁹ but these are often isolated and inconsistent, influenced by gaps in personnel, processes and resources.

Errors are rarely, if ever, usefully viewed as acts or omissions that are solely the responsibility of individuals. Examining medication management as a socioculturally mediated multi-step process builds an understanding of medication management as something that happens between people, within systems created by people. Increasingly we have an evidence base, not just of the risks, but also for what will make good patient and carer experiences and reduce expectation-experience gaps. Implementing this evidence requires attention to the specific challenges of different care locations, the

accessibility and presence of people to support medication management, and available resource for carers.

We propose two main challenges for researchers, clinicians and policymakers if we are to move from describing problems to a vision for change:

1. To develop whole system solutions for gaps which are currently either ‘patched-over’ by hidden work of people, or left exposed, risking harm. For example, there is remarkably little known about what would work best to evolve systems to limit carer and practitioner anxiety and allow for variation in carer desire for involvement in medication management³ while still serving patients in a timely and effective manner.
2. To develop an evidence-base for best practice in the ‘unattended to’ aspects of medicines management in palliative care, for example, making decisions to act – whether, for example, for carers to summon help with symptom control, nursing staff to administer as required or anticipatory medicines,^{2,4,8} or for a deprescribing review to be completed.⁶

Declaration of conflicting interests


The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Sally-Anne Francis  <https://orcid.org/0000-0003-2384-1518>

Joanne Wilson  <https://orcid.org/0000-0002-9144-6088>

Sarah Yardley  <https://orcid.org/0000-0002-1645-642X>

References

1. Yardley I, Yardley S, Williams H, et al. Patient safety in palliative care: a mixed-methods study of reports to a national database of serious incidents. *Palliat Med* 2018; 32(8): 1353–1362.
2. Wilson E, Morbey H, Brown J, et al. Administering anticipatory medications in end-of-life care: a qualitative study of nursing practice in the community and in nursing homes. *Palliat Med* 2015; 29(1): 60–70.
3. McCloskey B, Hughes C and Parsons C. A qualitative exploration of proxy decision makers’ expectations of prescribed medications for people with advanced dementia. *Palliat Med* 2018; 32(6): 1114–1123.
4. Bowers B, Ryan R, Kuhn I, et al. Anticipatory prescribing of injectable medications for adults at the end of life in the community: a systematic literature review and narrative synthesis. *Palliat Med* 2019; 33(2): 160–177.
5. Wilson E, Caswell G and Pollock K. The ‘work’ of managing medications when someone is seriously ill and dying at home: a longitudinal qualitative case study of patient and family perspectives. *Palliat Med* 2021; 35(10): 1941–1950.
6. Paque K, Vander Stichele R, Elseviers M, et al. Barriers and enablers to deprescribing in people with a life-limiting disease: a systematic review. *Palliat Med* 2019; 33(1): 37–48.
7. Kuruvilla L, Weeks G, Eastman P, et al. Medication management for community palliative care patients and the role of a specialist palliative care pharmacist: a qualitative exploration of consumer and health care professional perspectives. *Palliat Med* 2018; 32(8): 1369–1377.
8. Aitken C, Boyd M, Nielsen L, et al. Medication use in aged care residents in the last year of life: a scoping review. *Palliat Med* 2020; 34(7): 832–850.
9. Healy S, Israel F, Charles M, et al. Laycarers can confidently prepare and administer subcutaneous injections for palliative care patients at home: a randomized controlled trial. *Palliat Med* 2018; 32(7): 1208–1215.

Sally-Anne Francis¹ , Joanne Wilson²  and Sarah Yardley^{1,3} 

¹Marie Curie Palliative Care Research Department, University College London, London, UK

²Royal Free Hospitals London NHS Foundation Trust, London, UK

³Central and North West London NHS Foundation Trust, London, UK

Corresponding author:

Sarah Yardley, Marie Curie Palliative Care Research Department, UCL Division of Psychiatry, 6th Floor, Wing A, Maple House, 149 Tottenham Court Road, London, W1T 7NF, UK.
Email: sarah.yardley@ucl.ac.uk