Guideline Summary

Guideline Title

Medicines adherence. Involving patients in decisions about prescribed medicines and supporting adherence.

Bibliographic Source(s)

National Collaborating Centre for Primary Care. Medicines adherence. Involving patients in decisions about prescribed medicines and supporting adherence. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. 30 p. (Clinical guideline; no. 76).

Guideline Status

This is the current release of the guideline.

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Scope

Disease/Condition(s)

Any disease or condition including long-term conditions requiring use of medicines

Guideline Category

Counseling
Management
Prevention
Treatment

Clinical Specialty

Family Practice
Internal Medicine
Psychology

Intended Users

Advanced Practice Nurses
Health Care Providers
Hospitals
Nurses
Patients
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

Guideline Objective(s)

To offer best practice advice and make recommendations about how healthcare professionals can help patients to make informed decisions by facilitating the involvement of patients in the decision to prescribe, and how they can support patients to adhere to the prescribed medicine

Target Population

Adults aged 16 years and older, including those with comorbidities, learning disabilities or language and/or cultural differences.

Note: Groups that are not covered:

- Children and young people. However, the guideline recommendations may be considered for a child or young person who is deemed competent to express a view on their prescription.

Interventions and Practices Considered

1. Involving patients in decisions about medicines by establishing effective communication and providing needed information
2. Assessing and supporting adherence using the following interventions:
   - Suggesting that patients record their medicine-taking
   - Simplifying the dosing regimen
   - Discussing benefits and side effects of medicines
   - Discussing patients' concerns about medicine costs
3. Reviewing medicines
4. Communication between healthcare professionals

Major Outcomes Considered

- Clinical effectiveness
- Adherence to medicines
- Patient preferences
- Decisional conflict
- Contact with the care provider (communication)
- Health care behaviour
- Health status and well-being
- Patient knowledge and satisfaction
- Cost-effectiveness

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Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Primary Care (NCC-PC) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion

Documents" field for the full version of this guidance.

Clinical Effectiveness

Literature Search Strategy

Scoping Search

An initial scoping search for published guidelines, systematic reviews, economic evaluations and ongoing research was carried out on the following databases or websites: National Library for Health (NLH) Guidelines Finder, National Guidelines Clearinghouse, Scottish Intercollegiate Guidelines Network (SIGN), Guidelines International Network (GIN), Canadian Medical Association (CMA) Infobase (Canadian guidelines), National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines (Australian Guidelines), New Zealand Guidelines Group, BMJ Clinical Evidence, Cochrane Database of Systematic Reviews (CDSR), Database of Abstracts of Reviews of Effects (DARE) and Heath Technology Assessment Database (HTA), National Health Service Economic Evaluations Database (NHSEED) National Research Register and Current Controlled Trials.

Evidence Review for Guideline Development

The aim of the evidence review was to identify the most relevant, published evidence in relation to the key clinical questions generated by the Guideline Development Group (GDG). Reviews of the evidence using systematic methods relating to searching and appraisal of the evidence were conducted.

The following bibliographic databases were searched from their inception to the latest date available: Cochrane Database of Systematic Reviews (CDSR), Database of Abstracts of Reviews of Effects (DARE), HTA, MEDLINE, EMBASE, CINAHL, AMED (Allied and Complementary Medicine Database), CENTRAL (Cochrane Controlled Trials Register). When appropriate to the question PsycINFO was also searched.

The search strategies were developed in MEDLINE and then adapted for searching in other bibliographic databases. Systematic reviews and randomised controlled trials were searched for using methodological search filters designed to limit searches to these study designs. These were devised by the Centre for Reviews and Dissemination and the Cochrane Collaboration. The economic literature was identified by conducting searches in NHSEED and in MEDLINE and EMBASE using an economics search strategy developed by the School of Health and Related Research (ScHARR) at the University of Sheffield.

Databases of the results of the searches for each question or topic area were created using the bibliographic management software Reference Manager.

The search strategies for all questions or topic areas developed for the Medline database are detailed in appendix B of the full version of the original guideline document (see the "Availability of Companion Documents" field). Details of all literature searches for the evidence reviews are available from the NCC-PC. Further references were also suggested by the GDG.

How the Evidence Reviews Were Conducted

The research literature relating to shared decision-making and adherence is complex and overlapping. It was decided that individual literature searches for each clinical question would result in a duplication of work as the retrieved evidence would potentially overlap from question to question. Very focused searches would also be likely to miss relevant literature as terminology is not standardised. Broad searches were therefore undertaken to produce evidence reviews on each of the following key topics:

- Shared decision-making in the context of prescribed medicine
- Barriers to shared decision-making and adherence in the context of prescribed medicine
- Interventions to enhance adherence in the context of prescribed medicine

The retrieved evidence was then sifted and allocated to the relevant clinical question.

Additional focused literature searches were undertaken for some of the key clinical questions.Â Refer to section 2.3.3 of the full version of the original guideline document for details.

Identifying the Evidence

After the search of titles and abstracts was undertaken, full papers were obtained if they appeared to address the key clinical question. The highest level of evidence was sought. However, other types of quantitative evidence, qualitative evidence and expert formal consensus results were used when randomised controlled trials were not available. Only English language papers were reviewed. Following a critical review of the full text paper, articles not relevant to the subject in question were excluded. Studies that did not report on relevant outcomes were also excluded.

Update

Literature searches were repeated for the initial evidence-based questions at the end of the GDG development process allowing any relevant papers published up until June 2008 to be considered. Only those studies where recommendations needed substantial revisions were added in detail. Future guideline updates will consider evidence published after this cut-off date.

Health Economics Methods

Health Economic Evidence Review Methodology

The following information sources were searched:

- Medline (Ovid) (1966-June 2006)
- Embase (1980-June 2006)
- National Health Service Economic Evaluations Database (NHS EED)

- PsycINFO
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)

The electronic search strategies were developed in Medline and adapted for use with the other information databases. The clinical search strategy was supplemented with economic search terms. Titles and abstracts retrieved were subjected to an inclusion/exclusion criterion and relevant papers were ordered. No criteria for study design were imposed a priori. In this way the searches were not constrained to randomised controlled trials (RCTs) containing formal economic evaluations. Papers included were:

- Full/partial economic evaluations
- Considered patients over 16 years of age
- Written in English, and reported health economic information that could be generalised to UK

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence for Intervention StudiesÂ

1++: High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews of RCTs or RCTs with a high risk of bias*

2++: High-quality systematic reviews of caseâ€“control or cohort studies

High quality caseâ€“control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relation is causal

2+ Well-conducted caseâ€“control or cohort studies with a very low risk of confounding, bias or chance and a moderate probability that the relation is causal

2-: Caseâ€“control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal*

3: Non-analytic studies (for example, case reports, case series)

4 : Expert opinion, formal consensus

*Studies with a level of evidence 'â€“' should not be used as a basis for making a recommendation.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses
Systematic Review

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Primary Care (NCC-PC) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Clinical Effectiveness

Critical Appraisal of the Evidence

From the papers retrieved, the Senior Health Services Research Fellow (SHSRF) and the Health Service Research Fellow (HSRF) synthesized the evidence for each question or questions into a narrative summary. These form the basis of this guideline. Each study was critically appraised using the Institute's criteria for quality assessment and the information extracted for included studies is given in Appendix C of the full version of the original guideline document (see the "Availability of Companion Documents" field). The content and delivery of interventions was poorly defined in many studies and it was difficult to decide which studies should be included or excluded. The Guideline Development Group (GDG) advised on which studies to include and exclude in these circumstances. Background papers, for example those used to describe the concepts used in the guideline, were referenced but not extracted.

Choice of Outcomes

When agreeing key clinical questions the GDG discussed the choice of outcomes for each search. A variety of outcomes are currently found in studies on shared decision-making but the outcomes primarily looked at were patient preferences, identification of beliefs and patient agreement to the decision. Any additional information on factors which may have influenced the study results and had an impact on the wider implementation of an intervention, such as participants' age, ethnicity or social status; dropout rates and payments or rewards given to participants, were recorded in the evidence tables considered by the GDG. The primary outcome measure for all the evidence reviews on interventions to increase adherence was adherence. Adherence levels were the outcome also for studies examining medicine review.

Health Economics Methods

Health Economic Evidence Review Methodology

The full papers were critically appraised by a health economist using a standard validated checklist. A general descriptive overview of the studies, their quality, and conclusions was presented and summarised in the form of a narrative review.

Each study was categorised as one of the following types of full economic evaluation: cost-effectiveness analysis, cost-utility analysis (i.e., cost-effectiveness analysis with effectiveness measured in terms of quality-adjusted life years [QALYs] gained) or cost-minimisation analysis. Other studies which did not provide an overall measure of health gain or attempt to synthesise costs and benefits were categorised as 'cost-consequence analysis.' Such studies were considered partial economic evaluations.

Methods Used to Formulate the Recommendations

Expert Consensus
Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Primary Care (NCC-PC) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

The Guideline Development Group (GDG)

A Chair was chosen for the group and his primary role was to facilitate and chair the GDG meetings. The GDG consisted of a diverse multidisciplinary group with an interest and/or expertise in medicines adherence. The Chair, a general practitioner with special interest in epilepsy identified by the NCC-PC, oversaw the work of the group. Nominations for group members were invited from various stakeholder organisations, selected to ensure appropriate combination of members including healthcare professionals and patient representatives.

Each GDG member was expected to act as an individual expert in their own right and not as a representative of their parent organisation, although they were encouraged to keep their nominating organisation informed of the process. Nominees who were not selected for the GDG were invited to act as Expert Peer Reviewers and were sent drafts of the guideline by the Institute during the consultation periods and invited to submit comments using the same process as stakeholders.

Guideline Development Group Meetings

The GDG met on 12 occasions (with one two day GDG meeting), at approximately 2 monthly intervals over a period of 11 months and 6 weekly intervals over a period of 6 months to review the evidence identified by the project team, to comment on its quality and completeness and to develop recommendations for clinical practice based on the available evidence. The final recommendations were agreed by the full GDG.

Developing Key Clinical Questions

A series of key questions created from the scope was the first step in the development of the guideline. The key questions formed the starting point for the subsequent evidence reviews and facilitated the development of recommendations by the GDG. The key questions were developed by the project team with the guidance from the GDG. The full list of key questions is shown in appendix B of the full version of the original guideline document (see the "Availability of Companion Documents" field).

Forming Recommendations

In preparation for each meeting, the narrative and extractions for the questions being discussed were made available to the GDG one week before the scheduled GDG meeting. These documents were available on a closed intranet site and sent by post to those members who requested it.

GDG members were expected to have read the narratives and extractions before attending each meeting. The GDG discussed the evidence at the meeting and agreed evidence statements and recommendations. Any changes were made to the electronic version of the text on a laptop and projected onto a screen until the GDG were satisfied with these.

All work from the meetings was posted on the closed intranet site following the meeting as a matter of record and for referral by the GDG members.

Areas without Evidence and Consensus Methodology

The table of clinical questions in Appendix B of the full version of the original guideline document (see the "Availability of Companion

Documents" field) indicates which questions were searched.

In cases where evidence was sparse, the GDG derived the recommendations via informal consensus methods, using extrapolated evidence where appropriate. All details of how the recommendations were derived can be seen in the 'Evidence to recommendations' section of each of the chapters of the full version of the original guideline.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Chapter 10 of the full version of the original guideline is primarily concerned with presenting the methods and the results of literature reviews investigating the cost-effectiveness of adherence enhancing interventions. This is followed by a summary and discussion of the findings including a discussion of some of the methodological issues arising from the reviews. The Guideline Development Group used the evidence from the reviews when considering the possible cost-effectiveness implications of their recommendations.

There appears to be little good quality evidence evaluating the cost-effectiveness of adherence enhancing interventions, or evaluating the impact of nonadherence on cost-effectiveness of medicines. The published systematic reviews have been critical of the quality of the existing economic evidence base, and have tended to focus on critiquing methods rather than reporting cost-effectiveness per se. In particular, there appears to be little information to support UK decision makers. Few of the published economic evaluations were conducted from the perspective of the UK National Health Service (NHS). Methodological weaknesses including inadequate or missing sensitivity analyses, and also the predominance of disease specific outcome measures instead of quality-adjusted life years (QALYs), makes it difficult to generalise the findings of many of the studies to the UK context.

In general, and in particular for the UK context, there is a clear need for more and better research into the implications of nonadherence on the cost-effectiveness of medical interventions, and also to assess the potential of interventions to increase adherence to improve healthcare outcomes and/or reduce healthcare costs.

Method of Guideline Validation

External Peer Review
Internal Peer Review

Description of Method of Guideline Validation

The guideline was validated through two consultations:

1. The first draft of the guideline (The full guideline, National Institute for Clinical Excellence [NICE] guideline and Quick Reference Guide) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG)
2. The final consultation draft of the full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments

The final draft was submitted to the Guideline Review Panel for review prior to publication.

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Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Primary Care (NCC-PC) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Patient Involvement in Decisions about Medicines

Communication

Good communication between healthcare professionals and patients is needed for involvement of patients in decisions about medicines and for supporting adherence. Some patients may find it easier to communicate with their healthcare professional than others.

Healthcare professionals should adapt their consultation style to the needs of individual patients so that all patients have the opportunity to be involved in decisions about their medicines at the level they wish.

Consider any factors such as physical or learning disabilities, sight or hearing problems and difficulties with reading or speaking English, which may affect the patient's involvement in the consultation.

Establish the most effective way of communicating with each patient and, if necessary, consider ways of making information accessible and understandable (for example, using pictures, symbols, large print, different languages, an interpreter or a patient advocate).

Encourage patients to ask about their condition and treatment.

Ask patients open-ended questions because these are more likely to uncover patients' concerns.

Be aware that the consultation skills needed for increasing patient involvement can be improved.

Increasing Patient Involvement

Patient involvement in the decision-making process requires that healthcare professionals acknowledge patients' views about their condition and its treatment, and that both healthcare professional and patient have a role in making decisions about treatment. Simple interventions to increase patient involvement do not necessarily increase the overall length of consultation and may be justified by benefits, particularly over the course of a long-term condition.

Offer all patients the opportunity to be involved in making decisions about prescribed medicines. Establish what level of involvement in decision-making the patient would like.

Discuss with the patient why they might benefit from the treatment. Clearly explain the disease or condition and how the medicine will influence this.

Explain the medical aims of the treatment to patients and openly discuss the pros and cons of proposed medicines. The discussion should be at the level preferred by the patient.

Clarify what the patient hopes the treatment will achieve.

Avoid making assumptions about patient preferences about treatment. Talk to the patient to find out their preferences, and note any non-verbal cues that may indicate you need to explore the patient's perspective further.

Healthcare professionals have a duty to help patients to make decisions about their treatment based on an understanding of the likely benefits and risks rather than on misconceptions.

Accept that patients may have different views from healthcare professionals about the balance of risks, benefits and side effects of medicines.

Be aware that increasing patient involvement may mean that the patient decides not to take or to stop taking a medicine. If in the healthcare professional's view this could have an adverse effect, then the information provided to the patient on risks and benefits and the patient's decision should be recorded.

Accept that the patient has the right to decide not to take a medicine, even if you do not agree with the decision, as long as the patient has the capacity to make an informed decision and has been provided with the information needed to make such a decision.

Assess the patient's capacity to make each decision using the principles in the Mental Capacity Act (2005) (http://www.guidelines.gov/disclaimer.aspx?redirect=http://www.opsi.gov.uk/ACTS/acts2005/ukpga_20050009_en_1). To lack capacity patients must: (a) have an impairment of or disturbance or malfunction of brain and mind, and (b) demonstrate lack of capacity to:

- Understand the information relevant to the decision
- Retain information for long enough to use it in the decision
- Use or weigh information as part of the process of making the decision
- Communicate the decision (whether by talking, using sign language or any other means)

If the patient has specific concerns, record a summary of the discussion, because this may be helpful in future consultations.

Encourage and support patients, families and carers to keep an up-to-date list of all medicines the patient is taking. The list should include the names and dosages of prescription and non-prescription medicines and herbal and nutritional supplements. If the patient has any allergic or adverse reactions to medicines, these should be noted.

Understanding the Patient's Knowledge, Beliefs and Concerns About Medicines

There is evidence that patients make decisions about medicines based on their understanding of their condition and the possible treatments, their view of their own need for the medicine and their concerns about the medicine.

Be aware that patients' concerns about medicines, and whether they believe they need them, affect how and whether they take their prescribed medicines.

Ask patients what they know, believe and understand about medicines before prescribing new treatments and when reviewing medicines.

Ask if the patient has any specific concerns about their medicines, whenever you prescribe, dispense or review medicines. These may include concerns about becoming dependent on medicines and concerns about adverse effects. Address these concerns.

Be aware that patients may wish to minimise how much medicine they take.

Be aware that patients may wish to discuss:

- What will happen if they do not take the medicine suggested by their healthcare professional
- Non-pharmacological alternatives to medicines
- How to reduce and stop medicines they may have been taking for a long time, particularly those known to be associated with withdrawal symptoms

- How to fit taking the medicine into their daily routine
- How to make a choice between medicines if they believe they are taking too many medicines

Providing Information

Patients need information about their condition and possible treatments if they are to be involved in making informed decisions about medicines. The format and content of the information provided should meet the needs of individual patients.

Offer patients information about medicines before the medicines are prescribed.

Offer patients information that is relevant to their condition, possible treatments and personal circumstances, and that is easy to understand and free from jargon.

Check that patients have any information they wish about medicines when the medicines are dispensed.

Discuss information on medicines with the patient rather than just presenting it. The discussion should take into account what the patient understands and believes about the condition and treatment.

Do not assume that the patient information leaflets (PILs) that patients receive with their medicines will meet each patient's needs. (Note: PILs contain information for patients on how medicines should be used. It is a legal requirement that this information is included on the label or within the packaging of a medicine). Address concerns that patients may have after reading the standard PILs.

Patients differ in the type and amount of information they need and want. Therefore, the provision of information should be individualised and is likely to include, but not be limited to:

- What the medicine is
- How the medicine is likely to affect their condition (that is, its benefits)
- Likely or significant adverse effects and what to do if they think they are experiencing them
- How to use the medicine
- What to do if they miss a dose
- Whether further courses of the medicine will be needed after the first prescription
- How to get further supplies of medicines

Be careful not to make assumptions about a patient's ability to understand the information provided. Check with the patient that they have understood the information. Information for patients should be clear and logical and, if possible, tailored to the needs of the individual patient.

Suggest where patients might find reliable information and support after the consultation: for example, by providing written information or directing them to other resources (for example, National Health Service [NHS] Choices [http://www.guidelines.gov/disclaimer.aspx?redirect=http://www.nhs.uk/]).

Provide inpatients with the same information as patients in other settings. Information should include:

- What the medicine is
- How the medicine is likely to affect their condition (that is, its benefits)
- Likely or significant adverse effects and what to do if they think they are experiencing them
- How to use the medicine
- What to do if they miss a dose
- Whether further courses of the medicine will be needed after the first prescription
- How to get further supply after discharge

Supporting Adherence

Assessing Adherence

Patients do not always take their medicines exactly as prescribed, and healthcare professionals are often unaware of how patients take their medicines. The purpose of assessing adherence is not to monitor patients but rather to find out whether patients need more information and support.

Recognise that non-adherence is common and that most patients are non-adherent sometimes. Routinely assess adherence in a non-judgemental way whenever you prescribe, dispense and review medicines.

Consider assessing non-adherence by asking the patient if they have missed any doses of medicine recently. Make it easier for them to report non-adherence by:

- Asking the question in a way that does not apportion blame
- Explaining why you are asking the question
- Mentioning a specific time period such as 'in the past week'
- Asking about medicine-taking behaviours such as reducing the dose, stopping and starting medicines

Consider using records of prescription re-ordering, pharmacy patient medication records and return of unused medicines to identify potential non-adherence and patients needing additional support.

Interventions to Increase Adherence

Patients may need support to help them make the most effective use of their medicines. This support may take the form of further information and discussion, or involve practical changes to the type of medicine or the regimen. Any interventions to support adherence should be considered on a case-by-case basis and should address the concerns and needs of individual patients.

If a patient is not taking his or her medicines, discuss with them whether this is because of beliefs and concerns or problems about the medicines (intentional non-adherence) or because of practical problems (unintentional non-adherence).

Be aware that although adherence can be improved, no specific intervention can be recommended for all patients. Tailor any intervention to increase adherence to the specific difficulties with adherence the patient is experiencing.

Find out what form of support the patient would prefer to increase their adherence to medicines. Together, you and your patient should consider options for support.

Address any beliefs and concerns that patients have that result in reduced adherence.

Because evidence supporting interventions to increase adherence is inconclusive, only use interventions to overcome practical problems associated with non-adherence if a specific need is identified. Target the intervention to the need. Interventions might include:

- Suggesting that patients record their medicine-taking
- Encouraging patients to monitor their condition
- Simplifying the dosing regimen
- Using alternative packaging for the medicine
- Using a multi-compartment medicines system

Side effects can be a problem for some patients. If this is the case you should:

- Discuss how the patient would like to deal with side effects
- Discuss the benefits, side effects and long-term effects with the patient to allow them to make an informed choice
- Consider adjusting the dosage
- Consider switching to another medicine with a different risk of side effects
- Consider what other strategies might be used (for example, timing of medicines)

Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs.

Reviewing Medicines

Patients may use medicines long term. The initial decision to prescribe medicines, the patient's experience of using the medicines and the patient's needs for adherence support should be reviewed regularly. The patient's own list of medicines may be a useful aid in a medicines review.

Review patient knowledge, understanding and concerns about medicines, and a patient's view of their need for medicine at intervals agreed with the patient, because these may change over time. Offer repeat information and review to patients, especially when treating long-term conditions with multiple medicines.

Review at regular intervals the decision to prescribe medicines, according to patient choice and need.

Enquire about adherence when reviewing medicines. If non-adherence is identified, clarify possible causes and agree any action with the patient. Any plan should include a date for a follow-up review.

Be aware that patients sometimes evaluate prescribed medicines using their own criteria such as their understanding of their condition or the symptoms most troubling to them. They may, for example, stop and start the medicine or alter the dose and check how this affects their symptoms. Ask the patient whether they have done this.

Communication Between Healthcare Professionals

Patients may be under the care of healthcare professionals from different disciplines and specialties at the same time; responsibility for patients' care may be transferred between healthcare professionals, and medicines reviews may be carried out by healthcare professionals other than the prescriber. Therefore good communication between healthcare professionals is required to ensure that fragmentation of care does not occur.

Healthcare professionals involved in prescribing, dispensing or reviewing medicines should ensure that there are robust processes for communicating with other healthcare professionals involved in the patient's care.

On transfer between services (for example, between hospitals and care homes or on discharge from hospital), give all patients and subsequent healthcare or other providers a written report containing:

- The patient's diagnosis
- A list of all medicines the patient should be taking
- Clear identification of any new medicines that were started
- Clear identification of any medicines that were stopped, with reasons
- Clear information on which medicines should be continued after transfer from that service and for how long
- Any known adverse reactions and allergies the patient has experienced
- Any potential difficulties with adherence and any actions taken (for example, provision of a multi-compartment medicines system)

Healthcare professionals involved in reviewing medicines should inform the prescriber of the review and its outcome. This is particularly important if the review involves discussion of difficulties with adherence and further review is necessary.

Clinical Algorithm(s)

None provided

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Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The highest level of evidence was sought. In cases where evidence was sparse, the Guideline Development Group (GDG) derived the recommendations via informal consensus methods, using extrapolated evidence where appropriate.

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Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Improved adherence to medicines

Potential Harms

Not stated

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Qualifying Statements

Qualifying Statements

- This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer and informed by the summary of product characteristics of any drugs they are considering.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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Implementation of the Guideline

Description of Implementation Strategy

The Healthcare Commission assesses how well National Health Service (NHS) organisations meet core and developmental standards set by the Department of Health in 'Standards for better health' (available from http://www.guidelines.gov/disclaimer.aspx?redirect=http://www.dh.gov.uk). Â Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that NHS organisations should take into account national agreed guidance when planning and delivering care.

The National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (listed below). These are available on the NICE website (http://www.guidelines.gov/disclaimer.aspx?redirect=http://guidance.nice.org.uk/CG76):Â Â

- Slides highlighting key messages for local discussion
- National costing statement â€“ gives some financial background and context to the guideline
- Guide to resources â€“ gives information about a selection of resources available from NICE, government and other national organisations
- Patient information resource â€“ an information sheet for display in healthcare settings
- Audit support for monitoring local practice

Implementation Tools

Audit Criteria/Indicators
Patient Resources
Quick Reference Guides/Physician Guides

Resources
Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

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Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better
Living with Illness
Staying Healthy

IOM Domain

Effectiveness
Patient-centeredness

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Identifying Information and Availability

Bibliographic Source(s)

National Collaborating Centre for Primary Care. Medicines adherence. Involving patients in decisions about prescribed medicines and supporting adherence. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. 30 p. (Clinical guideline; no. 76).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2009 Jan

Guideline Developer(s)

National Collaborating Centre for Primary Care - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

Guideline Committee

Guideline Development Group

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Financial Disclosures/Conflicts of Interest

In accordance with guidance from the National Institute for Health and Clinical Excellence (NICE), all Guideline Development Group (GDG) membersâ€™ interests were recorded on a standard declaration form that covered consultancies, fee-paid work, share-holdings, fellowships, and support from the healthcare industry. Details of these can be seen in Appendix E of the full version of the original guideline document.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

Availability of Companion Documents

The following are available:

- Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. Full guideline. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. 364 p. (Clinical guideline; no. 76). Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Medicines adherence. Involving patients in decisions about prescribed medicines and supporting adherence. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence; 2009 Jan. 11 p. (Clinical guideline; no. 76). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. Costing statement. Implementing NICE guidance. London (UK): National Institute for Health and Clinical Excellence; 2009 Jan. 3 p. (Clinical guideline; no. 76). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Medicines adherence. Implementing NICE guidance. Slide set. London (UK): National Institute for Health and Clinical Excellence; 2009. 17 p. (Clinical guideline; no. 76). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Medicines adherence. Audit support. Patient questionnaire. London (UK): National Institute for Health and Clinical Excellence; 2009. 12 p. (Clinical guideline; no. 76). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- The guidelines manual 2007. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 April. Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Additional accompanying guideline materials can be found from the National Institute for Health and Clinical Excellence (NICE) Web site.

Patient Resources

The following is available:

- You and your prescribed medicines: enabling and supporting patients to make informed decisions. Understanding NICE guidance - Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence; 2009 Jan. 11 p. (Clinical guideline; no. 76). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

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This summary was completed by ECRI Institute on November 30, 2009.

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