



Multi-compartment Compliance Aids (Blister packs) Frequently Asked Questions for prescribers

GUIDELINE

Background

The Royal Pharmaceutical Society (RPS) recommends the use of original packs of medicines, supported by appropriate pharmaceutical care as the preferred intervention for the supply of medicines in the absence of a specific need for a multi-compartment compliance aids (MCA) [1]. In general there is insufficient evidence to support the benefits of MCAs in improving medicines adherence in patients and the available evidence does not support recommendations for the use of MCA as a panacea in health or social care policy, including in care home settings [2].

Care should be provided in a way that supports patient independence and reablement; MCAs can inadvertently perpetuate dependence and disempowerment. However, there is some evidence to indicate that MCA may be of value for a **small number** of patients **who have been assessed** as having practical problems in managing their medicines. Each patient's needs must be assessed on an individual basis and any intervention must be tailored to the patient's specific requirements.

NICE Guidance on managing medicines for adults receiving social care in the community recommends: [3]

- consider using a monitored dosage system only when an assessment by a health professional (for example, a pharmacist) has been carried out, in line with the Equality Act 2010, and a specific need has been identified to support medicines adherence.
- take account of the person's needs and preferences and involve the person and/or their family members or carers and the social care provider in decision-making.

Who decides when to use an MCA?

This should be based on a robust individual patient assessment ([Appendix 1](#)) and the [Department of Health and Social Care resource kit](#), community pharmacy usually assess patients to help decide the most appropriate method of dispensing.

MCAs may not always be the best solution; there are many other tools which can support patients with medicines use. It would be beneficial for pharmacist and prescriber to discuss this decision. It is useful for the prescriber to carry out a clinical medication review as part of the assessment, to see if therapy can be rationalised.

Who are MCAs for?

MCAs are for patients to manage their own medication and should not be initiated to support carers to administer medication. Where the patient has a formal carer, the carer should be trained to administer medicines from a labelled pack which has been supplied by a pharmacist or dispensing doctor - there is no requirement for the medicines to be supplied in an MCA.

Note: Patients who are not eligible for treatment under this statement may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. In this situation, follow locally defined processes.

Can a prescriber request that a patient has their medicines dispensed in an MCA?

If a prescriber thinks a patient might benefit from an MCA, they should refer the patient to their community pharmacist for a robust assessment of their needs, considering local health and social care services and procedures. Pharmacists must decide what reasonable adjustments they should make to their services. Removing a medicine from the manufacturer's packaging means that it is no longer licensed, and responsibility for the stability of the repackaged medicines transfers from the manufacturer to the pharmacist.

Do prescribers have to issue 7-day prescriptions for patients with blister packs?

Seven-day prescriptions are only needed if a joint decision has been made by the prescriber and pharmacist, on clinical grounds, that medication should be issued to the patient on a weekly basis. This would be appropriate for patients who are managing their medicines themselves and for whom receiving more than one MCA at a time may be confusing or dangerous.

It is important to be aware that if a 28-day prescription is issued, where weekly MCAs are filled, all 4 will be issued at once. This is a legal requirement under the pharmacy terms of service.

Should prescribers issue 7 day prescriptions for care homes?

Patients in care homes should not be issued with 7-day scripts. This should only be considered for individual patients who manage their own medicines, as in Q4 above. The cultural reliance on medicines supplied in monitored dosage systems (MDS) within care homes and care at home services should be challenged.

Are there any medicines which should not be put in an MCA?

The removal of a medicine from the manufacturer's original packaging and its repackaging into an MCA can affect its stability. The [Specialist Pharmacy Service](#) (SPS) website has information on medication suitable for packaging in an MCA. A user [guide to searching the SPS website](#) is available.

How should medicines that cannot be packaged in MCAs be managed?

Medicines such as inhalers, eye drops, creams and ointments etc. required in addition to MCAs add further complexity. Care providers and patients will have to deal with using several different medicines administration systems which may raise questions around the appropriate use of the MCA and increase the risks of the patient not receiving their medication correctly.

What happens if changes are made to a patient's medication if using an MCA?

Depending on the urgency of the changes, it may be more practical to implement them at the end of a supply cycle. If this is not possible, the prescriber should liaise with the pharmacist and patient/ carer to ensure changes are made safely and promptly. Prescribers should be aware that if there is a change midcycle, a new prescription needs to be issued for **all** medicines, and that the pharmacist should ensure that contents of previously issued MCAs are discarded.

How can medicines in an MCA be identified?

MCAs are labelled to include descriptions of each medicine they contain. However, many tablets look similar and when present in the same compartment they can be difficult to distinguish. This can lead to disempowerment of patients and carers e.g. if they are choosing not to take a medicine at a specific time for lifestyle reasons, such as a diuretic.

References

1. Royal Pharmaceutical Society. [Improving patient outcomes: The better use of multi-compartment compliance aids](#) July 2013
2. Royal Pharmaceutical Society (Scotland): [Improving Pharmaceutical Care in Care Homes](#) Dec 2012
3. National Institute for Health and Clinical Excellence (NICE). [Managing medicines for adults receiving social care in the community guidance](#). NICE Guideline 67, March 2017.

Acknowledgement to colleagues at Brighton and Hove CCG on whose document this policy was based

Appendix 1 Patient assessment criteria

1. The following criteria should be considered as part of the individual patient assessment and in the creation of assessment frameworks in support of the agreed care packages.
2. Involve the patient or carer in the decision-making process, including sharing information of the advantages, uncertainties and risks of different intervention options.
3. Involve a pharmacist, or a multi-disciplinary team including for example an occupational therapist, social worker, pharmacist with experience of applying knowledge of the pharmaceuticals, pharmacology, pharmacokinetics and stability of medicines, as well as the necessary clinical expertise, in the assessment of intervention options.
 - a. Consider all the available underpinning evidence and information including an assessment of:
 - b. Patient characteristics including, relevant medical history, physical and cognitive ability of the patient and nature of the care support available. This will include dexterity, memory, visual impairment, hearing impairment, literacy problems, language problems, health literacy learning disability, beliefs and choices. Any assessment should incorporate a clinical medication review.
 - c. The nature of the care support available is important because the needs of an individual patient self-administering are different to the needs of an institution providing care to an individual.
 - d. Whether non-adherence (if present) is intentional or non-intentional and for how long the patient has not taken their medication as prescribed. Explore these areas and address where possible.
 - e. Whether a history of consistent non-adherence could lead to adverse effects with interventions that suddenly ensure adherence e.g. high-risk medicines and drugs with a narrow therapeutic index, or those that increase the risk of falls.
 - f. All alternative intervention options which can assist the patient to take their medicines (e.g. simplification of regimen, medicines administration record (MAR) sheets patient reminder charts, pill press, pill punch, eye drop dispenser, prescription ordering, availability of professional and lay helpers to administer medicines from their original packaging, patient counselling services).
 - g. Current available evidence of medicines stability
 - h. Overall benefits and risks to the patient of supplying, or not supplying, within an MCA based on their individual needs.
4. Have an agreed plan for how the self-administration/prompting or administering of medicines not suitable for inclusion in an MCA (e.g. when inhalers eye or ear drops or “when required” are prescribed) will be managed and who will do this.
5. Involve effective communication pathways to support the transfer of care, between the prescriber, team supplying the MCA and patient receiving the MCA. Agreement from GP, pharmacy and social services to share appropriate information e.g. changes in medication and if the patient is in hospital.
6. Involve follow-up and regular review of the need of an MCA or other intervention on an individual basis. The circumstances leading to decision to supply medicines in an MCA may be temporary or resolve over time and an MCA may no longer remain the intervention of choice. Roles and responsibilities for this should be agreed as part of local arrangements.
7. Consider equality and disability discrimination legislation.
8. Involve appropriate record keeping and documentation to maintain an audit trail, to support decisions made.

From: Royal Pharmaceutical Society. [Improving patient outcomes: The better use of multi-compartment compliance aids](#) July 2013 .