THE MULTIDISCIPLINARY MEDICATION TEAM - A NURSING POINT OF VIEW

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The role of the Multidisciplinary Team involved in the assessment and rehabilitation of the elderly is well publicised. That of the team involved in assessment and aiding drug compliance is less so, and yet co-operation and co-ordination between this team will do much to reduce re-admission to acute elderly care units due to drug abuses.

In the past the situation was such that the medical practitioner made his diagnosis and prescribed the appropriate medication, the pharmacist dispensed the drugs and the nurse on ward administered them. On discharge from hospital the patient was handed his take home medication and there the hospital's responsibility ended.

Little or no formal education was given to anyone with regard to their diagnosis and ensuing treatment.

Occasionally, and only when pressed, could information be prized from the physician, the pharmacist was never seen and the bedside nurse would refer any query to the nurse-in-charge of the ward. However, we have progressed and educating the patient is no longer a low priority.

The problems associated with prescribing for the elderly are well documented- as highlighted by Atkinson et al[1]. Elderly people are likely to suffer from more than one disease and because of this may be prescribed a variety of different drugs. It is significant that a great

number of drugs may be prescribed for one old person, each to be taken in a different number and possibly at different times.

We are fully aware that this should not be the case, Dass et al[2] found that only 25% of elderly patients could manage to take no more than three preparations reliably during one period. Why then, are we surprised when our elderly fail to comply with complex drug regimes?

This basic problem is exacerbated by the possible non-selective self-medication of 'over the counter' drugs and further complicated by non-compliance.

PRESCRIBING PROBLEMS

1. Multiple pathology
2. Polypharmacy - possible adverse drug reactions
3. Non-selective self medication
4. Non compliance - for whatever reason

If we choose to describe non-compliance as Haynes[3], the extent to which the patients behaviour coincides with medical or health advice, should we not then have some firmly laid down plans for providing that advice from the moment the patient is admitted to the ward?

Nursing has moved on since Florence Nightingale first described a Nurse as 'someone who cares for the sick'. Not only has the basic educational standard for entry into nurse training been upgraded but specific courses are designed to increase the awareness of the nurse in specialised areas, as in the continuing education courses.

Courses also run to educate nurses to Diploma and Degree standard, thus broadening the outlook of the nurse from bedpans, bedmaking and coffee making for the medic too debilitated to maintain his own fluid balance. Nurses make up the largest single body in the field of health care, they are raising their awareness and professional standing.

They are no longer happy to provide simply the correct dosage of the correct drug to the correct patient at the correct time, their horizons have broadened to include a basic knowledge of pharmacokinetics and pharmacodynamics.

It is traditionally the role of the nurses to administer medication to patients in hospital, there is no reason why this should not continue, particularly in view of their increased awareness. If any other health care professional is willing to undertake this task with the assurance that they are 'relieving the nurse of this time consuming job' maybe they would also be willing to monitor blood pressure, temperature, pulse and respiration, observe excreta and bedbath, these also are time consuming. However, it is necessary that a policy is established with regard to the distribution of medication, providing the nurse with firm guidelines to adhere to, indicating the exact procedure for checking patients' identity, checking prescriptions against medication and finally administering. Formal means of identifying patients are also necessary; two means in general use are: a photographic measure, and the plastic name braclets. The former however is hardly practical in the acute setting unless there is a 24 hour photographer in the ward.

I would not presume to describe accurately the role of the other disciplines involved, however, I will make recommendation with regard to methods that would improve communications between nurses and other disciplines to the benefit of the patient.

Whenever possible in acute settings, a Pharmacy top-up system should be implemented allowing the pharmacist to visit the wards on a daily basis to retrieve medication for return, to check prescription sheets and to re-order ward supplies. Not only does this save valuable nursing time, wasted in checking and ordering supplies, it also allows the pharmacist time to act as a valuable information source to both medical and nursing staff, and also develop their role as a patient educators.

I would also suggest that a formal patient education plan is established in all settings where patients are discharged home on any medication, as in a study described by McGuire et al, in an acute medical elderly care unit where a self medication scheme was set up for all patients prior to discharge home alone or with minimal supervision. Medical, pharmacy and nursing staff co-operated to provide information to patients on a regular basis and to send them home with bottles they could open and instructions they could read, simple but effective.
In conclusion I would say that it is our duty to educate our patients and not only the elderly, with regard to their diagnosis, treatment and possible side effects of that treatment. In so educating, hopefully we

provide our patients with enough quality information to allow them to make rational decisions with regard to their bodies and treatment of those bodies. Thus, failure to comply would at least be an educated and informed decision.

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