published in The Hippocratic Post,
25 April 2016

link to The Hippocratic Post article [1]



Drugs to alleviate symptoms; drugs to prolong life; drugs to counteract side effects of other drugs. Doctors' prescribing powers in the face of illness have never been greater, and patients' lists of medicines to take have never been longer. By the time you are receiving care in a nursing home, it is quite likely that you will have accrued a substantial bag of medicines, proof perhaps of the heart attack or cancer that you have survived or the diabetes, depression and dementia that you may now present with.

It is great news that doctors have so many drugs available. But when prescribing the latest best remedy for yet another comorbidity, does the doctor consider the implications for the receiving end: the patients popping pills and the nurse doing the drug round?

An eyewitness account

During a 15-hour nursing shift looking after 20 residents in my local nursing home, I did the drug round at 8 am (110 tablets) 12 pm (25 tablets) 4 pm (46 tablets) and 8 pm (43 tablets). By 'tablets', I am referring to each type of tablet: so, for example, two paracetamol would count as 'one tablet' in the adding up.

That's quite a lot of tablets, especially when you consider that drugs for Parkinson's and diabetes really must be given on time whilst morphine, tramadol, warfarin and insulin all require two staff signatures for administration (and carers can be difficult to find when themselves struggling to cope with the personal care needs of the residents). Blood sugars need measuring before insulin is given, and recent legislation has meant that the entire contents of the tramadol box need counting every time it is in use.

Older residents also need time and assistance to swallow their tablets. They often view my arrival as an opportunity to be assisted to the toilet, not to take their medication. In many cases, it is necessary to gain (and continually regain) their trust in you before they will accept what you are offering.

Completing the circuit

I do spend an excessive amount of time completing my drug rounds, and yet, in a strange sort of way it has become an attractive challenge. Just as the Formula 1 drivers are timed for each sector of their racing lap, the progress of each sector of my drug circuit is measured against favourite TV programmes. So, I aim to be in room 15 as Alexander Armstrong bids a Pointless farewell and in room 20 for the adverts of Coronation Street.

Of course, residents' needs come first so sometimes my schedule goes out of the window, and rightly so. Yet I have heard that in some busy hospitals, each drug administration is time-stamped and logged in a computer, with disciplinary action taken if drugs are not given on time. I don't know how this works – even on a good shift, how can all residents each receive their medicine prescribed for 8 am? Only robots need apply for these jobs I think.

Patches, drops, syrups and pumps

It's not only tablets that we administer: eyedrops, eardrops, medicated creams, syrups, patches, powders, inhalers, injections, suppositories, bladder infusions and gastrostomy products are also on the daily list. Yet still, we are surprised, and slowed down, by novel ways of administering medication – such as the resident with Parkinson's who came to stay for a week with a very novel pump that administered apomorphine subcutaneously into the abdomen. We were not trained and he was not compliant and the drug round was delayed.

Yet just because such myriad routes and types of medicines exist, should we endeavour to use them all? The centenarian who is still prescribed statins for primary prevention? The man with severe Alzheimers who still receives his daily rivastigmine patch? The blind lady still receiving five types of eyedrop each day? Medication reviews are invaluable, and might just allow the nurse to spend real time with the resident, and the resident to experience less of a 'pill burden' – especially if swallowing is becoming difficult.

Polypills and pipe-dreams

In Willy Wonka's factory, Violet Beauregarde tested out a chewing gum that promised to deliver flavours of tomato soup, roast beef and blueberry pie in a single stick – but it went horribly wrong. In medical research, scientists have put forward the idea of a polypill: a generic beta-blocker, diuretic, aspirin, ACE inhibitor, folic acid and statin in a single pill that would reduce the number of pills to swallow. Concerns remain, however, about possible drug interactions and a lack of tailoring of treatment to individual need.

As with all areas of healthcare, the real solution lies in improved staffing to divide up the labour. Some dreams though are just daydreams: I was recently asked if I would do the drug round for 40 residents. No way.

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