Research Paper

Medicines management at home during the COVID-19 pandemic: a qualitative study exploring the UK patient/carer perspective

Sara Garfield1,2,3, Carly Wheeler1,2, Charles Boucher1,2,6, Mike Etkind1, Jill Lloyd1,2, John Norton1,2, Della Ogunleye1, Alex Taylor1,2, Marney Williams1, Tamasine Grimes4,6, Dervla Kelly5,6, and Bryony Dean Franklin1,2,3

1Imperial College Healthcare NHS Trust, London, UK
2NIHR Imperial Patient Safety Translational Research Centre, Imperial College London, UK
3UCL School of Pharmacy, London, UK
4School of Pharmacy and Pharmaceutical Sciences, Trinity College Dublin, Dublin, Ireland
5School of Medicine, University of Limerick, Limerick, Ireland
6ULCan, Health Research Institute, University of Limerick, Limerick, Ireland

*Correspondence: Sara Garfield, UCL School of Pharmacy, 29-39 Brunswick Square, London WC1N 1AX, UK. E-mail: s.garfield@ucl.ac.uk

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Abstract

Objectives To explore home medicine practices and safety for people shielding and/or over the age of 70 during the COVID-19 pandemic and to create guidance, from the patient/carer perspective, for enabling safe medicine practices for this population.

Methods Semi-structured interviews were carried out with 50 UK participants who were shielding and/or over the age of 70 and who used medicines for a long-term condition, using telephone or video conferencing. Participants were recruited through personal/professional networks and through patient/carer organisations. Participants were asked about their experiences of managing medicines during the pandemic and how this differed from previous practices. Data were analysed using inductive thematic analysis.

Key findings Patients’ and their families’ experiences of managing medicines safely during the pandemic varied greatly. Analysis suggests that this was based on the patient’s own agency, the functioning of their medicines system pre-pandemic and their relationships with family, friends, community networks and pharmacy staff. Medicine safety issues reported included omitted doses and less-effective formulations being used. Participants also described experiencing high levels of anxiety related to obtaining medicines, monitoring medicines and feeling at risk of contracting COVID-19 while accessing healthcare services for medicine-related issues. Effects of the pandemic on medicines adherence were reported to be positive by some and negative by others.

Conclusions Pharmacy staff have a key role to play by establishing good relationships with patients and their families, working with prescribers to ensure medicines systems are as joined up as possible, and signposting to community networks that can help with medicines collection.

Keywords: COVID-19, pandemic, medicines, shielding, elderly
Background

Medicines are the most common healthcare intervention. Prior to the COVID-19 pandemic, more than 8% of adult emergency hospital admissions and 25% of those for older adults were medication related, with increasing age and higher disease burden as key risk factors.\cite{1,2}

During the COVID-19 pandemic, people self-isolating and housebound for long periods, due to age or ‘extreme medical vulnerability’, were potentially at increased risk of medicine-related problems. Potential issues included: disrupted routine healthcare services and supply chains; altered household mobility, wellbeing and support structures; restrictions on or reluctance to attending healthcare; and misinformation about medicines reported to affect the risk or severity of COVID-19 infection. These create additional challenges for medicines safety, at a time when prevention of harm is particularly important.

Little is known about changes to household medicines practices or safety during a pandemic. Previous studies in pandemics and epidemics\cite{3–6} have not considered medicines safety from the viewpoint of patients/carers staying at home. In March 2020 in the UK, patients classified as ‘extremely clinically vulnerable’ were strongly advised by the government to ‘shield’, i.e. not leave their home. Pharmacists were paid a fee for home-delivery of medicines to patients on the shielding list. Those over 70 could access this service if other medical factors made them extremely clinically vulnerable. Community pharmacies experienced some staff shortages during this time where staff needed to shield or self-isolate.\cite{7} The objectives of this study were to explore home medicines practices and medicines safety for people staying at home as much as possible during the COVID-19 pandemic and to create best practice guidance for medicines management during a pandemic from the patient/family carer perspective. The study was carried out in two countries: the UK and Ireland. This article presents findings from the UK.

Methods

A qualitative cross-sectional study design was adopted, using semi-structured interviews. The study was approved by University College London Research Ethics Committee (reference: 18417.001) and the protocol was published.\cite{9}

Sampling and recruitment

A sample size of 50 was chosen due to anticipated diversity to support having sufficient information power.\cite{9} Participants were recruited using a combination of convenience and purposive sampling to interview a range of participants regarding medical conditions, numbers of medicines, ages, genders, living alone versus with others, geography and ethnicities.

Adults, living in the UK, were eligible to participate if they met the Government’s criteria for shielding during the COVID-19 pandemic and/or they were aged 70 years or more and were using at least one long-term medicine. Adults assisting in medicines management for an adult fulfilling these criteria were also eligible. Those under 18 years, unable to consent to interview, or without access to telephone or internet were excluded. One participant with limited English was included as she had a family member whom she asked to assist her during the interview.

Participants were recruited through the researchers’ own personal and professional networks, patient and carer charities and organisations, and engagement with our patient and public involvement (PPI) partners. Both social media and word-of-mouth were used to support recruitment. We kept a matrix of participants’ demographic characteristics and medicines to enable us to target later recruitment towards less well-represented groups.

Data collection

An interview topic guide was developed, and informed by a priori principles of routine lay medicines use\cite{10} (Supplementary Appendix 1). Informed consent was received from all participants prior to participation. Where possible, this was through an electronic signature or a signed hard copy of the consent form being posted. Alternatively, verbal consent was invited by audio-recorded telephone or video call, as approved by the ethics committee.

Interviews were conducted remotely, between June and August 2020, either by telephone or video conferencing, depending on participant preference. Interviews were conducted by two research pharmacists working in hospital and academic settings (SG, BDF) and a health services researcher (CW). All had previous experience in conducting qualitative interviews. Interviews were audio-recorded, transcribed verbatim and anonymised. In two cases where the recording failed, detailed notes were made immediately after the interview.

Data analysis

A constructivist–interpretive analysis approach was used, with the aid of NVivo. A coding framework was developed iteratively by SG, BDF, CW, TG and DK using Safety-I/-II perspectives\cite{11} and Schafheitle et al.’s medication work framework\cite{10} as sensitising concepts.\cite{12} A constant comparative technique enabled systematic organisation, comparison and understanding of similarities and differences in the data. An iterative approach was taken with analysis being conducted during data collection and emerging themes being explored further in remaining interviews. Nine interviews were checked for inter-coder reliability among SG, BDF and CW. The remainder of the interviews was then coded by SG or CW. Additionally, eight PPI representatives open-coded 48 interviews. Each PPI representative coded 12 interviews with each interview independently open-coded by two PPI representatives. Agreement of emerging themes was reached in an online nominal group session. The PPI analysis was subsequently integrated with that of the researchers and reviewed by all researchers and PPI representatives. All PPI representatives had previous training and experience in open coding.

The research was carried out and reported according to Standards for Reporting Qualitative Research.\cite{12}

Results

Participants

Fifty people were interviewed (16 males, 34 females; mean age 68 years, range 26–93 years). Seven identified as being from a non-white ethnic group (comprising Caribbean British, Black African, Asian British, Asian, Sri Lankan, Indian and Chinese ethnicities). Participants were from England, Scotland and Wales, with six living in rural areas, one in a semi-rural area, and 43 in urban areas. Ten were living alone. Nine reported having a more dominant role in helping manage medicines for another adult who was over 70 and/or shielding, compared with managing their own medicines and focussed on their carer role during the interviews; seven of these were female. The number of medicines being taken ranged from 1 to 17.
Diversity of experiences in managing medicines during the pandemic

We identified a wide range of experiences. Some participants reported there had been no change – either they already had delivery arrangements in place pre-pandemic which continued, or they continued to collect medicines from a local pharmacy during the pandemic. For others, there was a smooth transition from one supply system to another, such as a straightforward change to getting medicines delivered or collected by others. For others, there had been an initial 'crisis' period where obtaining medicines was very difficult at the beginning of the pandemic, which had then stabilised.

‘We moved from [pharmacy] which is impossible at the moment, you have to queue, etc. to another pharmacy. Obviously, there were basic problems at the beginning, not getting things or stuff, but it is all working itself out now.’ (participant 32)

For remaining participants, the pandemic served as a ‘ripping point’, exacerbating pre-existing challenges.

So [pre-pandemic] when you go to collect […] the things the doctor has been prescribing, the other stuff isn’t due for repeat, so you are constantly having to go and chase those.’ […]

‘Well, I had to have a prescription during the course of the pandemic and so I submitted it in the usual way and they went to the chemist and then I actually rang the chemist, because I was in lockdown, and I rang the chemist, and I do actually know them very well and they know me very well […] and they kindly said they would deliver it, which they did. It wasn’t very difficult. I think I’m lucky because I’ve been going to them for a long time, they’re not far away, I know them and there’s an awful lot in having a personal rapport with people when they actually know who they’re speaking to, it’s a great help.’ (participant 35)

‘My local pharmacy have been good that they have been trying to deliver if they could. I don’t know if I’ve been flagged up on their system but they phoned me and asked if I wanted it delivered and I said that it was okay, they could deliver to other people [instead] that might have needed it before, but they delivered it anyway.’ (participant 33)

‘The Friday morning before the lockdown happened on the Monday, he [pharmacist] rang me and said [name], you are [name of community organisation] aren’t you … and he said can I have the email addresses of the members so that I can give them, tell them that we wanted to do delivery and I also explained it’s data protection, we couldn’t give him but he could give me the leaflet [to disseminate] if he wanted.’ (participant 23)

‘And finally, two weeks ago, their community pharmacist based at the GP practice who does one day a week in the practice phoned me at home and she immediately understood the problem and kind of all the implications that meant for me as a partially sighted person who is supposed to be shielding at home, she said don’t worry, I will sort it out and that was great and then the prescription came through for all my six meds, so that problem was solved’. (participant 48)

Factors affecting the diversity of experiences

Four themes seemed to account for much of this diversity. First, many participants described their own proactivity, determination and perseverance. Some expressed the view that they were in a more privileged position than others due to knowledge of the healthcare system, financial resources or ability to self-monitor their conditions.

Second, some participants reported having strong support from family, friends and/or community networks that helped them manage their medicines, mostly by collecting them.

Third, interview data suggested that support from community and hospital pharmacy staff was variable, with some participants describing very positive experiences and others negative (Box 1). Two key subthemes emerged regarding participants’ experiences of...
pharmacy services: continuity and communication. Some reported having used the same local community pharmacy for many years with good relationships that continued through the pandemic. Others reported having to change from their usual community pharmacy at the beginning of the pandemic, either due to temporary closures of services or because the pharmacy was unable to deliver. In some cases, delivery services were organised through a separate team affiliated with a pharmacy chain and participants, therefore, lost continuity with their local provider. Communication between pharmacy staff and patients/carers, particularly where this was proactive, was also identified by participants as being important. However, many participants reported a lack of information or receiving misinformation. Loss of informal communication channels was reported by some as participants were not visiting the community pharmacy to collect medicines. Additionally, many reported challenges in contacting pharmacy staff at the beginning of the pandemic when they needed to rearrange medicines supplies or monitoring arrangements.

Fourth, the analysis suggested that the pre-pandemic functioning of the medicines management system affected its pandemic resilience. The most common issue identified was non-synchronised supplies of different medicines, caused by different order dates and lengths of supply, resulting in patients/carers having to obtain medicines several times each month. This made obtaining medicines more difficult while shielding. Additionally, some patients/carers obtained medicines from multiple places, such as from both community and hospital pharmacies. Others had different systems for medicines for different family members, with some being delivered and others not. In addition, when rearranging medicines supplies after the start of the pandemic, there was a ‘disconnect’ between prescribed medicines and those purchased over-the-counter.

The problem I have got is I don’t get prescribed [loratadine] as it is so cheap, I just buy it over-the-counter but as the pharmacy know I am shielding and everything, they really want it on a prescription, so they won’t sell it to me. (participant 27)

In addition to these four main themes, some participants reported roles that doctors had played by issuing prescriptions earlier, prescribing medicines that had been purchased over-the-counter pre-pandemic, or liaising with phlebotomy services to ensure continuity of medicines monitoring. Others reported that it was difficult to contact GPs at the start of the pandemic.

Analysis suggested that the above themes were more important in accounting for the diversity of experiences described than participants’ demographic characteristics. However, people of working age seemed more likely to report major changes to their routines during shielding that affected continuity, for example, if they needed to change from collecting their medicines from a pharmacy near work to one near home. Taking a large number of medicines did not necessarily lead to more difficulties if medicines management had been working well pre-pandemic. However, having multiple prescribers of medicines, e.g. community and hospital, appeared to make changes during the pandemic more complex to navigate.

Medicines outcomes related to the pandemic

Some participants described the negative effects of the pandemic on their health due to medicines issues experienced. For example, some had missed doses of medicines and others had been given less-effective formulations to avoid needing to use healthcare services.

My medication was way overdue and these are immunosuppressants, you can’t suddenly stop taking them, and I hadn’t had any for a couple of months. I was very acby (participant 37).

Even where medicines-related issues did not cause identifiable physiological harm, participants described feeling very anxious as a result. This is related to obtaining supplies of prescription or over-the-counter medicines such as paracetamol, getting monitoring tests done or concern about catching COVID-19 when accessing pharmacies or other healthcare services.

There was a lot of stress getting my medication. I didn’t have enough […] but the nurse did say, don’t worry it is not disastrous […] if you don’t have quite enough for a week […] but it is just a stress and the hassle if I am to get it all sorted out (participant 20).

The pandemic appeared to have a range of effects on adherence. Some participants reported increasing adherence to ensure their long-term conditions were fully under control to help protect them against serious COVID-19 infection. Change of routine could have a positive or negative effect. Positive effects were reported where participants felt they had more time to focus on their medicines because they were less busy, and negative effects where medicine-taking was integrated into a daily routine that was disrupted.

When I was forgetting to take my medicines before the pandemic, it was probably connected to having to rush out, […] in the morning, and this […] is kind of not a problem during shielding (participant 5).

I’ve struggled because I’m not going to work, my normal routine has been shot so I have regularly forgotten to take them in the morning (participant 3).

Negativity linked to the pandemic could also lead to reduced adherence. In addition, two participants reported reconsidering the risk/benefit ratio of taking the medicines that resulted in them needing to shield.

For many participants, all types of medication-related work identified by Schafheutle et al.13 changed or increased (Table 1).

Discussion

Patients’ and carers’ experiences of managing medicines safely during the pandemic varied enormously, with some participants experiencing difficulties, others little change and a small minority experiencing some improvements. This variation appeared to be based on the patient’s own agency, the functioning of their medicines system pre-pandemic, and their relationships with family, friends, community networks and pharmacy staff. Medicines safety issues included omitted doses and supply of less-effective formulations. There were mixed reports of the effects of the pandemic on medicines adher- ence. Aside from issues related directly to medicines safety, participants described experiencing high levels of anxiety about obtaining medicines, medicines monitoring and feeling at risk of contracting COVID-19 while accessing healthcare services to have medicines administered or monitored.

To the best of our knowledge, this is the first study to explore medicines safety for people who are shielding/over 70 during a pandemic from the patient/carer perspective. Our study was enhanced by the inclusion of a range of people in data analysis, including PPI representatives.

Our recruitment strategy sought to recruit as diverse a range of participants as possible and to address safety from both Safety-I and Safety-II perspectives,14 with recruitment not being limited either...
to those experiencing or not experiencing medicines-related issues. Nonetheless, our findings suggest that many of our participants had a higher-than-average knowledge of the healthcare system. Those people we did not reach may have experienced more difficulties with their medicines during the pandemic. However, a survey carried out with people with disabilities[13] reported those with a higher educational level experiencing more difficulties with obtaining medicines during the pandemic. The reason for this remains unclear. Despite our relatively large sample, new themes were constantly emerging during data collection and we cannot be sure that our sample size led to theoretical saturation. [14] Despite efforts to increase the number of male participants, more females than males participated; this may be because they were more likely to assist with others’ medicines.

Laypeople’s anxiety or difficulties about accessing healthcare were also reported during the Ebola and H1N1 ep/pandemics,[15–17] giving this finding cumulative validity. Recent research investigating laypeople’s medication use during the COVID-19 pandemic has focused on individual disease states rather than those housebound due to (extreme) medical vulnerability.[20–23] These studies considered broader aspects of disease management and did not explore lay medication-related experiences in-depth. This limits comparison with our findings. Nonetheless, variable effects on medication-related experiences in-depth. This limits comparison with our findings.

Our study findings contribute to the development of both the medication work framework[10] and a Safety-II approach,[11] i.e. understanding factors that create resilience in medicines systems. First, there were examples of all areas of medication work categorised by Schafheutle et al.,[10] increasing as a result of the pandemic. This suggests that the pandemic added to the illness management burden and may have made it more difficult to provide care that was minimally disruptive to patients’ and carers’ lives.[24]

We also identified a considerable increase in medicines-related anxiety that did not fall under Schafheutle et al.’s[10] initial definition of emotional work, suggesting it could be helpful to broaden this definition. Second, in relation to resilience, Fylan et al.[13] identified the important role of patients and their families in creating resilience in medicines management after hospital discharge. Our study further suggests that this role is also important in other situations, such as during a pandemic, and that it can be extended to wider community networks. As the pandemic was a novel situation, participants may have been unable to draw on past experiences. However, they drew on anticipatory resilience[27] (proactively making a decision or taking a course of action that has an expected consequence in a given situation—such as ordering medicines earlier to maintain supply) and responsive resilience[27] (reacting effectively when a situation changes—such as setting up/accessing community delivery services).

Implications for Practice and Policy
The findings suggest that pharmacy staff can make a significant difference during a pandemic, both through proactive, empathic
communication with patients/carers and by maintaining continuity in pharmacy services where possible. Our study did not find examples of misinformation regarding medicines themselves but did reveal examples of misinformation and/or miscommunication about services to access medicines, suggesting this as an important area for pharmacy staff to focus on. Pharmacy staff may not be able to meet all patients’/carers’ expectations regarding delivery, without reimbursement for this service. However, a clear explanation and signposting of patients/carers to alternative forms of delivery could be a potential solution, in addition to encouraging patients/carers to order medicines earlier than usual (see Supplementary Appendix 2 for advice for patients/carers co-designed with PPI representatives). Pharmacy staff can also help by liaising with GP practices to help ensure patients’ medicines request dates are synchronised to avoid multiple pickup/delivery each month and that prescriptions are issued early enough to allow extra time for delivery. Changing to two-monthly prescriptions may also be appropriate. These recommendations are also potentially helpful for housebound patients beyond the pandemic. We believe that the key factors that are important to patients regarding medicines management are likely to be consistent across countries although systems for addressing these may vary.

Conclusions

Our findings suggest considerable diversity in patients’/carers’ experiences of medicines management when staying at home during the COVID-19 pandemic, and that this is partly linked to the provision of pharmacy services. Pharmacy staff can play a key role by establishing good relationships, maintaining continuity in service provision, working with prescribers to ensure medicines ordering dates are as synchronised as far as possible, and facilitating medicines delivery.

Supplementary Material

Supplementary data are available at International Journal of Pharmacy Practice online.

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Author Contributions

TG and DK conceived the study with subsequent adaption for the UK context by BDF and SG. TG, DK, SG, BDF, CW, JN, ME, MW, JL and AT contributed to the study design. SG, BDF, and CW collected the data. All authors contributed to data analysis. SG and CW drafted the paper. All authors were involved in editing the manuscript and approved the final version.

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Conflict of Interest

None declared.

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