



# South Yorkshire Integrated Care System Position Statement Appropriate Use of Monitored Dosage Systems (MDS)

This document is intended for health and social care staff

Monitored dosage systems (MDS) are medication compliance aids where a person's medicines are dispensed by a pharmacy into compartments divided into days of the week and times of each day. These compliance aids have been increasingly used over recent years, often without a personalised assessment as to whether an MDS is suitable for a person. There may be other more suitable interventions that could better support someone to take their medicines.

People should be supported with medicines in a personalised way, balancing their wishes, needs and risks. Original packaging (which is how a pharmacy usually supplies medicines in a box or container with a pharmacy label including instructions) is the preferred method of supplying medicines, in line with Royal Pharmaceutical Society (RPS) and National Institute for Health and Care Excellence (NICE) guidance. Both advise that an MDS **should not be the first-choice intervention** to help people to manage their medicines.

**NICE NG67 states:** '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. (see link on page 3)

An MDS should not be requested by providers where staff are supporting with medication as this is not a patient-centred intervention. **Professional care providers should refer to their local authority procedures and training package to assist them in the administration of medication in original packs as per National guidance.**

**Please note that pharmacies are not obliged to provide medicines in an MDS, and some pharmacies may charge for doing this.**

**RPS** recommend that a holistic individual assessment is used to determine the most appropriate support. This involves a person-centred and collaborative approach. The person and their carer should be involved in discussions and choosing what suits them. To make sure an MDS is suitable for the person, the person needs to be assessed considering their characteristics, needs and expectations. (see link on page 3)

An MDS is one adherence intervention amongst many. Alternative interventions that are available may be more suitable.





The chosen method of support should always ensure that the following '6 R's' of medication support, which are promoted by Care Quality Commission (CQC) and can be demonstrated: -

- ❖ Right person
- ❖ Right medication
- ❖ Right route
- ❖ Right dose
- ❖ Right time
- ❖ Right to refuse

Demonstrating that the '6 R's' have been followed can be more challenging and time consuming if using an MDS because it is difficult to differentiate one medication from another when using an MDS. This can be particularly challenging when recording administration to evidence that each individual medicine has been given.

Examples of **risks** when using MDS are summarised below: -

- Loss of autonomy and choice around people's medicine taking, where medicines are only administered/taken because they are in the MDS.
- Disempowers people if they cannot identify specific medicines in the compartment that they want to take or not, for example, diuretics.
- Dispensing errors may occur during repackaging and labelling, which are unlikely to be identified by a person or their carer as it is difficult to identify individual medicines in MDS.
- MDS produce a large amount of plastic waste and create a greater carbon footprint than other compliance aids.
- If a person has medicines that are not suitable for an MDS this can potentially create more confusion and lead to missed medicines. Confusion and errors may occur if MDS and original packs used together.
- Reduces a carers knowledge, skills and understanding of medicines and their use, including how, why, and when they should be administered.
- Insufficient data and resources available on the stability of medicines when stored outside of the manufacturer's original packaging.
- Removal of a medicine from the manufacturer's original packaging and repackaging it into a Multi-Compartment Compliance Aids or MDS is often an unlicensed use, affecting stability of the medicine and increasing the level of risks, liabilities, and responsibility.
- A person may not receive their medicines correctly if the MDS system cannot accommodate dosing instructions, leading to adverse effects or poor health outcomes. For example, take before food, take when required, varied doses (some pharmacy robots that generate MDS are unable to accept varied doses)
- An MDS creates significant additional workload for GP practice, pharmacy teams both in the community and hospital as well as others involved in the prescribing and dispensing of medicines. Medication changes cannot always be made in a timely manner leading to potential patient harm. This additional work can also lead to delayed discharge and transfer of care.





**This position statement will be accompanied by a suite of templates to support the pre-assessment and continuing review of the provision of MDS. A patient information flyer is also in development.**

**These documents will be circulated when the suite is complete.**

For further guidance and information:

- GPhC Equality guidance for pharmacies: [click here](#)
- West Yorkshire Health and Care Partnership: Managing medication: [click here](#)
- CQC guidance: Multi-compartment compliance aids (MCAs) in adult social care | Care Quality Commission [click here](#)
- Case study carried out by Taunton & Somerset NHS Foundation Trust: Ensuring appropriate use of monitored dosage systems: [click here](#)
- NICE NG67 Managing medicines for adults receiving social care in the community [click here](#)
- **RPS members** can access a more comprehensive list of risks via RPS website by clicking [here](#).
- PrescQipp Bulletin 321: Multi-compartment compliance aids: [Click here](#)

If you have any further queries relating to the information above, please contact:

Barnsley Medicines Management Team  
E-Mail: [syicb-barnsley.mrsenquiries@nhs.net](mailto:syicb-barnsley.mrsenquiries@nhs.net)

Doncaster Medicines Optimisation Team  
E-Mail: [syicb-doncaster.medicinesmanagementadmin@nhs.net](mailto:syicb-doncaster.medicinesmanagementadmin@nhs.net)

Rotherham Medicines Management Team  
E-Mail: [syicb-rotherham.medicinesmanagement@nhs.net](mailto:syicb-rotherham.medicinesmanagement@nhs.net)

Sheffield Medicines Optimisation Team  
E-Mail: [syicb-sheffield.medicinesoptimisation@nhs.net](mailto:syicb-sheffield.medicinesoptimisation@nhs.net)

## Acknowledgements

- Kirklees Council
- Barnsley Area Prescribing Committee
- West Yorkshire Health and Care Partnership

