

Unit 1: Introduction to Quality Use of Medicines

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Principles of Quality Use of Medicines, subject code MPP201T, is the first core theory subject of M.Pharm Pharmacy Practice, Semester 2. It carries 4 credits and 60 hours of theory, taught at 4 hours per week, for 100 marks, and its five units are of equal length at 12 hours each in the PCI scheme. Its scope, as the syllabus states it, is to impart the basic knowledge and skills required to practice quality use of medicines in different healthcare settings and to promote quality use of medicines in clinical practice through an evidence based medicine approach. One wording note belongs at the start: Unit 1 of the syllabus prints the abbreviations QMC inside two item names, building blocks in QMC and evaluation process in QMC, in a unit otherwise entirely about QUM. The draft teaches those two items as the building blocks and the evaluation process of quality use of medicines, which is the only reading the surrounding text supports, and the verified record flags the printed form openly. No prevalence statistics, policy figures, guideline specifics or drug doses are stated anywhere in these notes, because the syllabus prints none and each of those belongs to a current guideline, list or label that a working pharmacist checks at the time of use.

1.1 What quality use of medicines means: the definition

Quality use of medicines, shortened to QUM, means that medicines are used wisely, safely and effectively, so that the people who need a medicine get the greatest benefit it can give with the least harm and waste it can involve. The definition has three tests built into it. Wise use means the decision to use a medicine at all, and the choice of which medicine, is made judiciously, on evidence and on the needs of this patient, with a non drug option considered where one exists. Safe use means the medicine is used in a way that minimises harm, with its risks known, watched for and managed. Effective use, sometimes stated as appropriate use, means the right medicine reaches the right patient in the right form for long enough to do its work, and its effect is checked. QUM is therefore not a property of a medicine. A good medicine used for the wrong indication, in the wrong patient, without explanation or without review, fails QUM, and an ordinary medicine chosen well, explained well and reviewed honestly passes it. That is why the subject is about decisions and systems, not about products.

1.2 The principles of QUM

The principles of QUM are the working form of the definition, and textbook teaching states them as a small set of linked commitments. First, primacy of the person: the patient, not the prescription, is the centre, and the patient's informed choice, circumstances and experience of treatment are part of quality, not an extra. Second, partnership: quality is produced jointly by prescribers, pharmacists, nurses, other health professionals, patients and carers, and no single partner can deliver it alone. Third, consultative and collaborative practice: partners share information, respect what each discipline knows, and resolve medicine problems together rather than in sequence and in silence. Fourth, support for consumer and professional education: people use medicines well when they understand them, and professionals prescribe and dispense well when their learning is current. Fifth, evidence informed decision making: choices rest on the best available evidence, read critically, applied to the individual. Sixth, monitoring and accountability: use is observed, problems are detected, outcomes are evaluated and practice changes on what is learned. An examination answer should state the principles and then show one operating in a named activity, for example partnership operating in a medication review, or monitoring operating in an adverse reaction report that changes a local guideline.

Principles of quality use of medicines



Wise, safe and effective use is the outcome the principles produce

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Figure: The principles of QUM. Wise, safe and effective use is the outcome; the six principles are how a service produces it.

1.3 Why QUM matters: benefit, harm and waste held together

Every medicine carries benefit and risk in the same package, and the syllabus objectives name both in one line: know the benefits and risks associated with the use of medicines. Used well, medicines relieve symptoms, cure infection, control long term disease and prevent events that have not yet happened. Used poorly, the same medicines harm through adverse reactions and interactions, fail through wrong choice or poor use by the patient, and waste scarce money in households and in health systems alike. QUM matters because all three failures are, in large part, preventable by better decisions rather than by better molecules: a clearer indication, a better matched choice, a warning given and understood, a review that stops a medicine whose work is done. For the Pharmacy Practice student the point is professional: the pharmacist is the partner whose daily work sits exactly at those decision points, at prescribing support, at dispensing, at counselling and at review, which is why this subject opens the second semester.

1.4 Key partners in QUM and their responsibilities in overview

The key partners of the syllabus are everyone whose decisions touch a medicine between its selection and its effect. Government and policy makers set the conditions: which medicines are registered and available, how they are priced, subsidised and listed, and what national policy says about their use. Regulatory authorities guard the quality, safety and efficacy of what reaches the market and act on safety information after marketing. Prescribers choose, for this patient, whether and what to prescribe, and remain responsible for review. Pharmacists assure the medicine supplied, check the prescription against the patient, counsel on use, detect medicine related problems and feed learning back to prescribers. Nurses and other health professionals administer medicines in institutional care, observe effects at the bedside and are often the first to see a problem. The pharmaceutical industry develops, manufactures, labels and promotes medicines, and its information shapes prescribing for better or worse. Patients and carers are partners, not recipients: they decide whether and how a medicine is actually taken, and their report of effect and harm is evidence no record can replace. Community and consumer organisations carry the public voice into policy and education.

1.5 Responsibilities of the partners, partner by partner

Responsibility in QUM is specific, and a strong answer assigns each duty to the partner who can actually perform it. The prescriber's responsibility is a defensible choice: a clear indication, a medicine selected on

evidence and on this patient's other medicines, conditions and preferences, directions the patient can follow, and a plan for review, including when to stop. The pharmacist's responsibility runs across the supply: verifying the prescription for legality, appropriateness and interaction, supplying a quality product with correct labelling, counselling so the patient leaves knowing what the medicine is for, how to take it, what to expect and what to report, and documenting and communicating any problem found. The patient's responsibility, supported and never blamed, is to use the medicine as agreed, to keep and share an accurate list of all medicines including non prescription and complementary products, and to report benefit and harm honestly. The health organisation's responsibility is the system around them all: formularies, guidelines, prescribing and dispensing systems that make the right choice the easy choice, incident reporting without blame, and education time. Industry responsibility is taken up in full in Unit 4: honest information, quality manufacture and no promotion that outruns the evidence.

1.6 The building blocks of QUM

The building blocks are the foundations on which quality use rests, and they are best taught as the infrastructure a country and a service need before individual good practice can be expected. The first block is sound policy: a national medicines policy of the kind Unit 2 meets through the essential medicines list, stating how medicines will be selected, supplied, financed and used. The second is reliable information: independent, current, evidence based information for professionals and plain language information for patients, because decisions are only as good as the information inside them. The third is education: undergraduate, continuing and patient education that keeps knowledge and skill current. The fourth is a quality assured supply system: registration, good manufacturing and distribution practice, and access to the medicines the policy selects. The fifth is monitoring and evaluation, the subject of the next section: systems that watch how medicines are actually used and what they actually do. Remove any one block and the others strain: guidelines without supply produce frustration, supply without information produces waste, and everything without monitoring produces confidence without knowledge.

1.7 The evaluation process in QUM

Evaluation is the process by which QUM work finds out whether it worked, and it follows the same cycle whatever the scale, from a single ward intervention to a national programme. It begins by defining the problem and the question precisely: which medicine use, in which patients, measured how. Baseline information is then gathered before any change, because without a before picture no after picture proves anything. Indicators, the measurable signs chosen in advance, carry the evaluation: prescribing indicators, dispensing and administration observations, patient knowledge and reported outcomes, and safety reports, each chosen because it reflects the quality the intervention claims to improve. The intervention is implemented as planned and the same indicators are measured again in the same way. Results are compared honestly, including where nothing improved, and the findings are fed back to the partners whose practice is involved, in a form they can act on. The cycle then repeats or moves to the next problem. Evaluation so described is not research decoration: it is the accountability principle of Section 1.2 with its sleeves rolled up, and the pharmacist who can run a small, honest evaluation of a medicine use problem holds a core Pharmacy Practice skill.

The QUM evaluation cycle, step by step

Define the medicine use problem and the question

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v

Measure the baseline with indicators chosen in advance

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v

Plan and implement the intervention with the partners

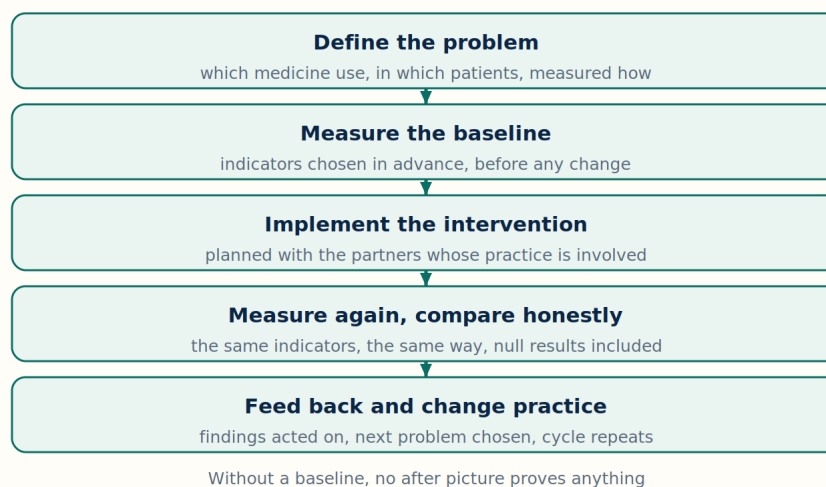
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Measure again in the same way, compare honestly

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v

Feed findings back, change practice, choose the next problem and begin the cycle again

The QUM evaluation cycle



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Figure: Evaluation as a cycle, not an event. The baseline is what makes the result believable.

1.8 Communication in QUM

Communication is named as its own syllabus item because most medicine failures are, at the point of failure, communication failures: an instruction misunderstood, a warning never passed on, a change of therapy that reached the ward and not the discharge summary, a patient who never said the tablets made her dizzy because no one asked in a way she could answer. Communication in QUM runs in three directions. Between professionals it means complete, accurate and timely transfer of medicine information at every handover, in writing where the record must carry it, with the reason for a choice stated and not only the choice itself. Between professional and patient it means counselling in plain language, checking understanding by asking the patient to say the plan back, providing written information to support the spoken word, and inviting questions and reports of problems as part of treatment rather than as complaints. Within the public sphere it means honest, balanced information about benefits and harms, from campaigns and consumer information, that neither oversells a medicine nor frightens people away from one they need. The pharmacist appears in all three directions, which is why the syllabus gives communication a full item and why Unit 3 returns to it inside multidisciplinary care.

1.9 Cost effective prescribing

Cost effective prescribing is the discipline of achieving the treatment goal at the lowest cost consistent with safety and effectiveness, where cost means the whole cost of the therapy and not only the price on the box. Its logic is sequential. First, is a medicine needed at all, or will a non drug measure, watchful waiting or

stopping an existing medicine serve the patient better at no drug cost and no drug risk. Second, where a medicine is needed, is there a choice of equal effectiveness and safety for this patient at lower cost, the question the essential medicines concept of Unit 2 answers at policy level and the prescriber answers again at the bedside. Third, is the form, duration and quantity right, with no automatic continuation past the point of benefit and no waste through quantities the patient will not use. Fourth, are the hidden costs counted: monitoring the therapy requires, managing its adverse effects, and the far larger cost of a cheap therapy that fails and is replaced by hospital care. Cost effective prescribing is not cheap prescribing. A more costly medicine that prevents a serious outcome the cheaper one cannot prevent may be the cost effective choice, and the examination point is always the reasoning, outcome per unit of total cost, never price alone.

Decision question	Cost effective answer looks like	Wasteful answer looks like
Is a medicine needed?	Non drug care or review first where evidence supports it	A prescription written because it is expected
Which medicine?	Equal benefit and safety at lower total cost	A costlier choice with no added benefit for this patient
How long and how much?	Duration and quantity matched to the goal, with a review date	Open ended continuation with no review
What follows the prescription?	Monitoring and adverse effect costs counted in the choice	Price compared alone, consequences ignored

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