Cluster Pharmacist Discharge Medication Reconciliation Project

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Background

- Pre-COVID 2 x 0.8 WTE Clinical pharmacists in N. Pembs Cluster covering 8 practices
- Time in practice allocated according to list size – (twice weekly / weekly / fortnightly visit)

Background

- Wide variability in how practices:
  a. Import DAL (WCCG v Print from WCP / Scan / docman)
  b. Time taken to action (24 hours v 2-3 weeks)
  c. Allocate meds rec to staff

Different Pathways in Practices

Admin → workflow to GP → Duty Dr (same day)

workflow to GP → Named GP (same day v admin slot)

Admin → workflow to pharmacist → Visit to practice

Pt request meds from discharge → Receptionist / Script Clerk access DAL via WCP, print and amend meds (ERRORS) and issue script, scan DAL to record

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Workflow to GP / pharmacist to check

Background

- As pharmacy teams in hospital lead on medication-related aspects of hospital discharges, the integration of Clinical pharmacists into GP practice enables a similar service to be developed in Primary Care, triggering medication reconciliation to ensure no unintentional changes are made to patient's medication and delivering continuity of care on transfer across care settings, with the goal that by 2030 all patients that transfer from one care setting to another will receive formal review of their medicines from the pharmacy team.

(Welsh Pharmaceutical Committee, April 2019: Pharmacy: Delivering a Healthier Wales).

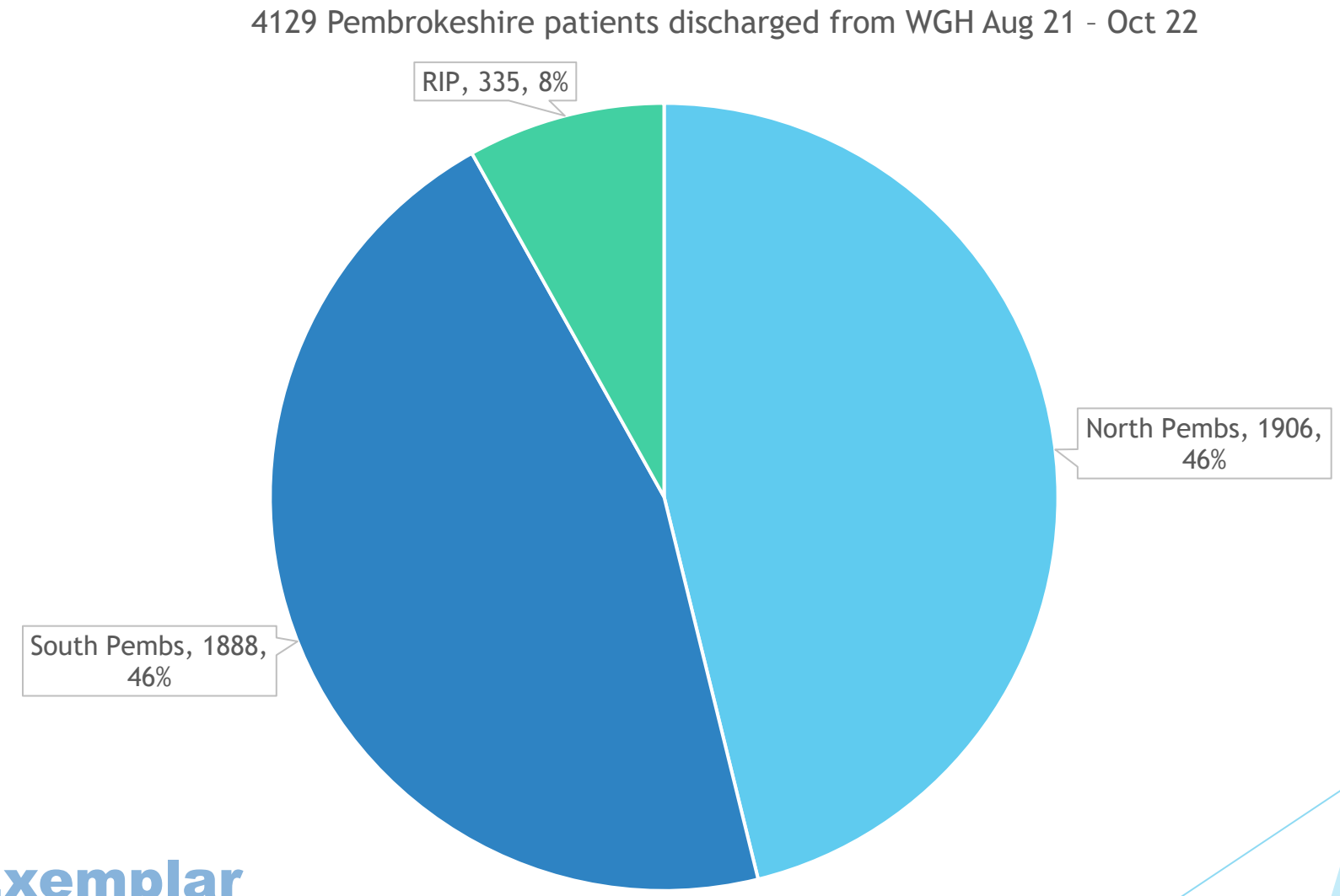
Project Aim

"Standardise and streamline process of medication reconciliation across participating practices, working across care settings to rapidly and safely act on information shared and release capacity for Clinicians in practice".

Project Design

- Patients discharged from WGH wards in the preceding 24-hours identified via WCP “recently discharged patients”
- Demographic details for each pt accessed to establish registered GP (approx 50% of pts not registered to N.Pembs practice).
- Remote access to individual surgeries is used to clinically review and reconcile medication
- Pilot in 4 practices
- Opt-in by 7 (of 8) practices by Nov 2021-> unsustainable workload

Reporting Figures



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Reporting Figures 2021- 2022

- 1697 records in practice accessed by Cluster Pharmacist to action DAL:
- 223 Actioned by practice staff (11 errors identified)
- 793 DAL not imported to records at time pharmacist actioned (46%)
- 389 Recommendations for monitoring / intervention (23%)
- 195 Contacts WGH/ Clinical Specialists (11%)
- 219 Contacts with Community Pharmacy (13%)
- 2 Yellow cards were identified for completion
- 6 Datix forms were completed

Total 1737 actions by cluster pharmacist in addition to updating repeat rx meds

Common Themes

- DAL not read as whole document before reviewed in Primary Care
- Lack of info – indication for new meds;
  - why medicines stopped / withheld;
  - rational for prescribing high risk combinations (eg) / MDT discussion / risk/ benefit discussions;
  - monitoring of therapy
  - duration of treatment
- Ongoing supply – hospital only medicines marked “yes” in GP repeat column

Common Themes

- Hospitals that don't use MTED discharged with HP10 with no copy for GP
- Patients discharged to care
- Communication with Community Pharmacy re changes
- Draft / no DAL to go with medicines list
- DAL not in practice, available on WCP

Project Feedback

From GPs

“I’ve found the project extremely useful and time saving”

“not only [do] you do medicines reconciliation but you also summarise the discharge in the patient records which is extremely helpful.”

“I struggle to keep track of when you are and aren’t working so my only suggestion is that it would be great if there was funding for a team of pharmacists who can cover each other’s work. “

“I really appreciate your discharge summary work. It’s so nice when I go to do one and then see that it’s all ready sorted so I can move on to other things. It helps the work load and makes sure that an important task is done promptly”

Project Feedback

From Community Pharmacy

“extremely beneficial service to us a community pharmacy, and definitely improves the help and care we can provide to our patients”

“especially helpful when dealing with patients who are on DDS/dosette boxes - changes to these sorts of prescriptions need to be highlighted quickly, this is something Ruth and her team are brilliant at.”

“Surgeries are very busy and difficult to get quick responses from, but the cluster pharmacy team that support us in dealing with DMR's and discharge medicines allow for queries to be dealt with and solved quickly, so that the patients will be receiving the correct, up-to-date medicines following their discharge from hospital.”

“Ruth and her team are a great resource for us in community pharmacy, and without whom there may have been delays in patients receiving their correct medicines.”

From Tertiary Centre Pharmacist

“This patient had a complex drug history due to frequent hospital admissions with the GP record not reflecting these admissions. [The medication] was stopped during admission in Morriston”

Where Next???

- Findings presented at Senior Pharmacist Leads Meeting (HDHB) 02/22, and asked to join MTeD working group
- Work shared with Secondary Care Colleagues to illustrate time can take to action advice in Primary Care (workload, capacity, appointments, practice systems and variability)
- Project considered to have proven need “Guardian Angel” role
- ?? Funding for ongoing uptake/adoption of successful Cluster Project
- IT solutions for patient identification would release pharmacist time for patient contact
- Identification and review of high risk patients (eg Temporary Residents)

Any Questions / comments?

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