Improving the supply of medication for patients discharged from the Emergency Department out of hours

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A patient story – Does it sound familiar?

“They gave me a piece of paper when I was discharged at 10pm and told me to come back to the hospital the next day to get my medication from the hospital pharmacy. I got a taxi home then caught two buses to come back at 10am. A neighbour came over to look after my kids whilst I came back to the hospital. The extra trip cost me £4 and took a total of 3 hours”

Introduction

40% of ED attendances occur out of hours when there is no pharmacy provision. As a result patients depend on the supply of medication out of hours from the Emergency Department ‘TTO’ [To Take Out] cupboard. If the medication is not available from the TTO cupboard they may be told to return to the hospital pharmacy the next working day, given a prescription (called an FP10) for an external pharmacy, told to see their GP or even given an inferior (available) medication. None of these options are desirable. The extra steps involved cost more time and money for patients or their carers/family.

Process for dispensing medications

Benchmarking pharmacy opening hours

Outcome Measures

- **FP10 usage (surrogate marker)**
  
  In this trust FP10s were kept in the ED TTO cupboard and prescribe if medications were not available. Use was logged but not restricted – ease of access that was not varied during the QIP. As a surrogate marker as it was easily measurable, an accurate reflection of TTO dispensing and allowed us to see emerging trends of prescribing.

- **Staff survey**
  
  The staff survey (amongst other things) looked for perceptions of ease of access in the preceding months and asked if an improvement had been noticed.

Key identified problems

Selection of drugs stocked did not match what clinicians needed to prescribe (the micro guidelines) nor were allowed to prescribe (the PGDs for non-prescribers). Stocking was inefficient with little thought to resting stock levels, poorly utilised IT solutions, lack of clinical oversight and feedback resulting in frequent stock shortages. Lack of structured approach to re-stocking resulted in substantial problems when the usual technician responsible was on leave. Solutions were planned and enacted as per the driver diagram above. Due to the time lags between requesting new stock lines and their delivery the changes did not occur in one single large event.

Key Lessons

The QIP was effective in improving the stock levels and range within the TTO cupboard which would have a positive impact on patients/carers. A better metric to use in this QIP might have been patient satisfaction telephone surveys comparing those who were given their TTOs and those who were not. However this would be highly time consuming to undertake and would have a huge array of confounding factors.

The main lesson was the value of ongoing clinical oversight/leadership in this area. Whilst having an impact on patient experience there is no clear mortality benefit nor associated funding. As such it is easy to overlook this area. My failure to effectively hand over my role on leaving the trust had a demonstrable impact on the dispensing from the ED - I had not ensured full sustainability of my project.

Results

The first two stars show change events (large stock level adjustments, new stock lines added/removed, more cupboard space created by removing unneeded stock lines etc). They were associated with falls in the use of significant FP10s. [All other variables were checked and were unchanged including attendance rates]

Staff surveys also reported reducing occasions when TTOs cannot be provided at point of discharge. The large variability seen just before the 3rd star reflects national stock shortages of multiple antibiotics during late December and January and its knock on effect on this project. Declining performance after the 3rd star was due to my leaving the trust and my role not being taken over by another colleague.

What next?

The QIP demonstrated that dispensing in EDs can be improved upon and gave an example of how to do so. There is to date no national guidance on dispensing from Emergency Departments, nor around what medications should be stocked (compared to very clear guidance on the contents of the ED antedote cupboard). I am working with RCEM to produce best practice guidance around dispensing medication from the Emergency Department and appropriate drugs to stock.

References

2. Department of Health. Delivering the out of hours review. Securing proper access to medicines in the out of hours period. London: DoH; 2004
4. Middleton T. Using pharmacy services innovatively to deliver medicines out of hours. Pharmaceutical Journal 2006;277:71