**MEDICINES OPTIMISATION FROM HOSPITAL TO HOME: Isle of Wight Community Pharmacy Re-ablement**

**PROJECT AIMS**
To identify people in hospital with a high risk of medicines related problems on discharge and refer these patients to their community pharmacy
To assess the impact of community pharmacy domiciliary visits on patients
To reduce avoidable and unnecessary readmission to hospital for medicines related issues

**Results:** The admissions, length of stay and excess bed days of the 208 people who received the service were compared for 2 years pre and post project against the 227 who were referred but did not have community pharmacist visits. Those who had a pharmacist review had:

- Fewer admissions: Review 2 patients to prevent 3 admissions per year
- Fewer bed Days: for each patient reviewed avoid 12 bed days/year
- Shorter length of stay: for each patient reviewed avoid 4.5 excess bed days/year

**Patients:**
- Are 55% less likely to have a 30 day readmission,
- Report better understanding of community pharmacy services and increased likelihood of contacting them.

**Pharmacists:**
- Reported enhanced understanding and awareness of these high risk patient needs

**Lessons learned:**
- Awareness that patients in hospital may need support with medicines on discharge was poor. A team approach to identifying and referring patients for pharmacist intervention increased awareness.
- Over half of the referrals were not actioned. Ensuring that there is a two way process for referral and feedback is important.
- Community pharmacists valued greater involvement with patients, but many did visits after work hours due to the need for a pharmacist to be on site during dispensing, this is not sustainable.

G.Honeywell; R.L.Howard; J.G.Warner; K.A.Noble; V.L.Rowse.