Piloting a supported medicines discharge from hospital.

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Background
There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remains a significant problem.

The Problem
11-22% hospital admissions for exacerbations of chronic conditions are a direct result of non-adherence with medicines. 30-70% of patients have an error (or unintentional change) when care is transferred.

When new medicines are prescribed in hospital, adverse reactions occur in up to 20% of patients after discharge. 50% of patients are non-adherent. 60% of patients lack information. 50% report a problem with new medication at 10 days.

Aims
The project looks at whether early identification of adverse reactions and resolving other medicines related problems when patients are discharged from hospital can improve adherence and prevent readmission.

Method
Post discharge, patients who are able to visit their local community pharmacy are referred using a secure website system Pharmoutcomes. Patients who are housebound and living in urban areas receive a domiciliary visit from a hospital pharmacist.

Lessons learned

Referrals to Community Pharmacies over the first few weeks were much lower than anticipated. An analysis of patients excluded was undertaken. This indicated many eligible patients lived outside catchment area.

Outcomes (Interim)

Number of referrals to Community Pharmacy using Pharmoutcomes and Community Pharmacy response Oct 2015 to April 2016

Comparison of Support Requested by Hospital Pharmacy and Support provided by Community Pharmacy (Oct 2015 – April 2016)

Number of referrals to Hospital Pharmacist for domiciliary visit and response March 2016-April 2016

Results of interventions (by type) by Community Pharmacist (Oct 2015 – April 2016) and Hospital Pharmacist (March 2016-April 2016)

Conclusions

Figures obtained pre-pilot did not reflect numbers of patients expected to be referred. In practice there was a need to re-evaluate eligibility criteria. 100 patients have been successfully referred to their community pharmacy for medicines support following discharge from hospital.

Some community pharmacies were not engaging with process. Patients not contacted. Individual pharmacies contacted and process explained. Referral rates for domiciliary visits lower than expected from Elderly care wards. Referral extended to housebound on other wards.

Essentials to continue Pilot

Education of hospital pharmacy staff to assess patients and refer engagement of community pharmacist to deliver services. Expansion of inclusion criteria. Enthusiasm to continually drive the project forward.

Achieved so far

Since the pilot started, approximately 100 patients have been successfully referred to their community pharmacy for medicines support following discharge from hospital.

Pharmacists have provided a variety of services to enable patients to manage their medicines at home.

Looking Forward

Referral of patients on discharge to community pharmacy to become routine practice.

Funding for pharmacist(s) to visit hospital wards.

Audits

1. Admission rates pre and post pilot study.
2. Patient satisfaction survey.