STANDARD 2.0 EPISODE OF CARE

Patients' medicines requirements are regularly assessed and responded to in order to optimise their outcomes from medicines.

2.1 ON ADMISSION OR AT FIRST CONTACT

Patients' medicines are reviewed: to ensure an accurate medication history, for clinical appropriateness and to identify patient in need of further pharmacy support.

Hampshire Hospitals NHS Foundation Trust

At Hampshire Hospitals, an electronic prescribing system helps to ensure the accuracy of prescriptions during medicines reconciliation. Doctors, pharmacists and medicines management technicians carry out medicines reconciliation for all newly admitted patients. The electronic prescribing system shows the full medication history for any previous admissions, which can be used to help ensure the accuracy of current medication and review any changes. On discharge, patients receive a list of all their medicines including the full discharge summary. An electronic copy is also sent to the GP and to the patient's nominated pharmacy, if they are using a monitored dosage system.

The Trust are now exploring how the electronic prescribing system can be used to further improve accuracy around medication history and communications with colleagues in the community, especially for those patients on complex regimes and/or taking high risk drugs.

Milton Keynes Hospital NHS FT

Introduction of a newly designed prescription chart that enables medication histories to be accurately documented on the chart as part of the admissions/medicines reconciliation process. This section needs to be signed off to show that medicines reconciliation has been done and drug history is up to date.
This simple re-formatting of the existing drug chart has ensured that medicines reconciliation is undertaken for all patients and all relevant information is clearly visible and accessible, rather than potentially buried in the patient's notes.

University Hospitals Bristol NHS FT

All medicines management technicians across the region are trained in comprehensive drug history taking and medicines reconciliation using the SW accredited training scheme. Any issues are flagged to the ward pharmacist. A key benefit of this scheme has been to free up time for pharmacists to focus on more clinical issues and the patient experience, such as appropriate counselling on medicines, providing patient information etc.

2.2 CARE AS AN INPATIENT

Patients have their medicines reviewed by a clinical pharmacist to ensure that their medicines are clinically appropriate, and to optimise their outcomes from their medicines.

NHS Tayside

NHS Tayside have developed Clinical Standards that aim to prioritise patients with the most needs and helps to manage clinical services to wards Within a day of admission to acute receiving wards 95% of patients will have a documented medication history, a pharmaceutical care plan with a priority code attached and the NHS Tayside Prescribing and Administration Record screened. The priority codes are assigned based on the patient's age, number of medicines, any high risk medicines taken and frailty; each code determines how often the patient is visited by a pharmacist on the ward, based on agreed timescales e.g. every 24 hours etc. The service has been very well received by medical, nursing and pharmacy staff; with further plans to look at patient feedback around the service. Pharmacists now have more time available for the most complex patients and are able to attend clinical ward rounds with medical staff. The scheme has also enabled more junior pharmacists to manage complex patients with peer review from seniors, thereby contributing to staff development.

Leeds Teaching Hospitals NHS Trust

The Integrated Medicines Optimisation on Care Transfer (IMPACT) project. Patients admitted to the older people admission wards at Leeds Teaching Hospitals NHS Trust were assessed by clinical pharmacists and pharmacy technicians to determine if they had a medicines related need post-discharge. Where a need was identified, a Medicines Care Plan (MCP) was added to the patient's discharge communication. Patients were signposted to healthcare professionals in primary care for follow-up action where appropriate. These included community pharmacists (for referrals to the new medicine service and post-discharge medicine use reviews), practice pharmacists (for clinical medication reviews), GPs, district nurses, practice nurses (e.g. for review of inhaler technique) and community matrons. Where there was no obvious person in primary care to refer to, patients were followed up by a hospital based pharmacy technician either by telephone or a domiciliary visit. A retrospective case review of all MCP patients who were readmitted was performed by a consultant physician for older people and a consultant pharmacist to determine whether the re-admission was drug related. The Trust is currently looking at how to take this project forward and secure funding to be able to provide this as an on-going service for other high-risk patients.

Calderdale and Huddersfield NHS FT

At Calderdale and Huddersfield NHS FT, some wards offer self-administration of medicines. On admission patients undergo a self-administration assessment and are assigned a level which demonstrates their knowledge about their medicines and their competence to self-administer, during their stay. Patients that self-administer will access their medicines, kept in the bedside-locker, at the appropriate times and record that they have self-administered on the drug chart record. Nurses and pharmacists regularly review charts to monitor self-administration and note any omissions. Research on the scheme has shown that patients are much happier when self-administering their medicines; they feel more in control of their condition and on discharge have a better understanding about their medicines. In particular, Parkinson's patients are able to take their medicines exactly when they need them and are able to manage their condition much better.

Royal Derby NHS FT

At the Royal Derby NHS FT, self-administration of medicines is default for all adult patients admitted to the Trust. Every patient is assumed to be able to self-administer unless they are proven otherwise, using an assessment tool i.e. patients have to 'opt out'. Self-administering patients are given the key to their bedside medicines locker and charts to help prompt them to take their medicines. Pharmacy and nursing staff regularly monitor charts to ensure that medicines are being taken and identify any issues. By using this 'opt out' scheme, the number of patients that self-administer one or more medicines in the Trust has risen from 3% to nearly 40%, with excellent feedback in the Trust patient survey.

2.3 MONITORING PATIENTS' OUTCOMES

Patients' outcomes from and experiences of treatment with medicines are documented, monitored and reviewed.

Aintree University Hospitals NHS FT

An electronic prescribing web portal identifies lab results that are out of range and potentially highlights drugs that are an issue. Electronic notes can be left for doctors to review the drugs and/or any drug related issues. Some of the benefits of this system are that it gives pharmacists the ability to highlight issues more easily and quickly than before; prioritises patients for pharmacy in-put and ensures that complex patients are monitored more closely; highlights suitable preventative measures e.g. DVT risk. The system is also able to link to lab sensitivity data, so that appropriate antibiotic prescribing can be monitored. The data can be accessed anywhere inside or outside hospital and is a useful resource for the on-call pharmacy service, ensuring that patients are clinically monitored on a regular basis.

Aintree University Hospitals NHS FT

The electronic prescribing web portal is regularly used to produce a doctor's job list, following a ward visit by the pharmacist to address any issues that have been identified. This ensures that there is a clear job list for doctors to action. In addition, the electronic note on the patient's file can only be removed by the pharmacist once any issues are rectified, thereby ensuring that action is taken. The system has proved to be an efficient use of staff time and improved communications.

Milton Keynes Hospital NHS FT

Annual Medicine Incident Away Day introduced to share learning from medication incidents. The department was aware of lots of reporting around medication incidents, but with few demonstrable outputs, or feedback. The pharmacy department organised a multi-professional away-day for 40 members of staff from across the hospital. The day aimed to identify what could be learned from errors; that everyone has a role in preventing errors and how could they get all departments involved. The away-day was successful in that staff feel there is now a more positive culture of reporting. Whilst there is still work to do to maintain this positivity, there has been a definitive change in culture and awareness of medication errors, as something that everyone has a role in. The 'away-day' will be repeated annually and feed into the Trust patient safety groups.

Wishaw General Hospital – NHS Lanarkshire

In Wishaw General Hospital, there is a daily 5-minute briefing with all staff on wards. Pharmacists take part in these briefings and used these as an opportunity to raise any issues or concerns about general medicines across the hospital, including learning from medication errors etc. The aim is to pass on information from across the hospital and help raise awareness.

2.4 CARE FOR PATIENTS NOT ADMITTED (e.g. outpatients, outreach, homecare)

Patients who are taking medicines at home or in non-acute care settings, have access to continuing supplies of medicines and to pharmacy services and support appropriate to their care.

Leeds Teaching Hospitals NHS Trust

Technicians in Leeds hospital provide Homecare services in HIV, liver and paediatrics to address complex medicines regimens, unlicensed medicines and over supply e.g:

- Many adult HIV patients come into the hospital to pick up their medicines; the technicians monitor and manage prescription renewal, liaising with consultants and set up the supply. When patients come to pick up their medicines, they talk to them regarding any issues, especially around adherence and side effects, and help to identify any problems. This system has helped to limit waste around HIV medication, as well as provide additional support for patients.
- There is a similar process for patients taking medication for their liver condition; with often the same ward technician managing the Homecare supply. Patients build good relationships with the technician whilst they are an inpatient following liver transplant and the technician helps them with any medicines related issues before, during and after the discharge process.
- The technician for the paediatric Homecare service also has a supply monitoring function; they will liaise with suppliers and manufacturers around complex, often unlicensed formulations, any supply issues and inform clinical specialists of any problems that may arise.

Calderdale Huddersfield NHS FT

Have a 'virtual ward team' in place. This is a multidisciplinary team, based within the Trust that includes community matrons, in-hospital screening nurses and pharmacy staff. The focus of the team is to reduce re-admissions of high-risk patients to hospital. The team liaise with a range of care providers within the patient's community e.g. community nurses, GPs, community pharmacists, about any medication issues that the patient may have, such as clinical reviews, compliance, medicines reconciliation at the GP practice, appropriate treatment of UTIs, warfarin monitoring. There is also some liaison with social services, especially where a patient may not be coping with their medicines, or any other issues. Post-discharge pharmacy staff will contact patients and, if requested by the patient, will arrange for a home visit to review how well the patient is coping with their medicines and assess their concordance etc. These visits can vary; some patients may require repeat visits or referral to other members of the multidisciplinary team.

The virtual ward aims to reduce re-admissions within 30 days of discharge; support patients with their medicines to get the best out of them; improve concordance; improve medicines reconciliation with GPs and ensure effective communications amongst the care team supporting the patient to give the best possible care.
The scheme is well accepted across the organisation and has received positive feedback from patients.