Medicines optimisation for older people living with frailty in community settings during COVID-19

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Consultant Pharmacist, Care of Older People

Community based role (local and national role)

- *Expert Practice*
- *Professional Leadership*
- *Education and Mentoring*
- *Service development, Innovation and Research*

Interests

- *Polypharmacy, Adherence, Patient centred care*
- *Local Clinical Pharmacy teams in community*
- *Medicines in care homes and domiciliary care settings*
- *Whole systems and pharmacy-led approaches to medicines optimisation in older people (frailty and multi-morbidity)*

Overview

- The GSTT Integrated Care Pharmacy (ICP) Team
- Patient facing role : Referral and communication pathway
- Non-patient facing role :Training and professional advice/support
- COVID experience: Opportunities, challenges and lessons learnt
- Now what?

GSTT Integrated Local Services

- Provide Adult Community Health Services across Lambeth and Southwark London Boroughs.
- Partnership with Local CCGs, Trusts, local authorities and voluntary/community groups to provide holistic seamless care

Pharmacy Team input

Community teams with active and routine input

- Community nursing (district nursing)
- Local Integrated Rehabilitation Services (LIR)
  - Enhanced Rapid Response team
  - Supported Discharge team
  - Urgent care (with social services)
- Care Homes support team (Pharmacy input to nursing homes only)

Other Teams referring to pharmacy team

- GPs/PCNs teams and CMDT
- Older people Assessment /Frailty Unit case management
- Social care

Optimising medicines use for older people living with frailty and multimorbidity closer to home

Consultant pharmacist

- Sees most complex
- Oversees team and drives vision
- Quality: Challenge poor practice and improve standards
- Advocating for patient centred care
- Strengthening the voice for medicines optimisation
- Spreading best practice "do once, share approach

ICP Pharmacists/Technicians (assigned to specific teams)

- Provide direct patient care
- Enable wider workforce to deliver medicines optimisation
  - Education and Training
  - Advice and support
  - Governance and safe processes

Pharmacy-led medicines optimisation pathway for frailty in community settings (Pre-COVID-19)

Target group

Frail older person during periods of vulnerability & deteriorating health e.g ToC
Advanced/Consultant Level Pharmacist input

Stable frail older person
Generalist Pharmacist input

Single access point

- Community teams
- Care Homes CMDTs
- GPs, PCN pharmacists Community pharmacy
- *Elderly care Acute*
  - Frailty Unit
  - Older People Assessment Unit (AOPU)
  - Admissions meeting
- Social services and third sector

STEP 1
Frail older people at high risk from medicines, proactively identified by health and social care practitioners during
- Routine care and refer to ICPs
-MDMs
-Safety briefings

STEP 2
ICP Undertake face to face patient centred Comprehensive assessment of needs at home & Jointly agrees plan

STEP 3
Liaise with others to facilitate Implementation of care plan

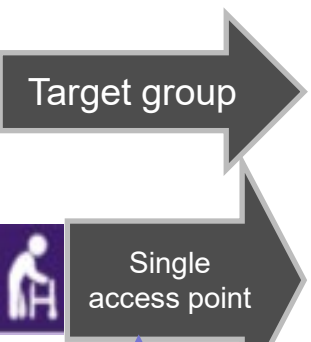
STEP 4
Monitor & review until stable

STEP 5
Practice pharmacists Community pharmacy
implements specific long term goals within care plan & liaise with GP and multidisciplinary teams
Refer to ICP and other specialists as needed

Patient-centred, outcome focused approach reviews

For more information: kelly.ebeh@gstt.nhs.uk

Pharmacy-led medicines optimisation pathway for frailty in community settings (During COVID-19)



Target group

Single access point

Community teams

Care Homes

GPs, PCN/ practice pharmacists

Frail older person at risk of medicnes related problems during COVID

Advanced/Consultant Level Pharmacist input

Stable frail older person

Generalist Pharmacist input

STEP1

Frail older people at high risk from medicines, proactively identified by health and social care practitioners undertaking

- Immediate health and social care assessment (H&SCA) in home environment
- MDMs
- Safety briefing

Triage

STEP 2

ICP Undertakes REMOTE or face to face consultation resolve immediate safety or medicines related need

STEP 3

Liaises with others to facilitate Implementation of care plan

STEP 4

Monitor & review until stable

STEP 5

Practice pharmacists
Community pharmacy
implements specific long term goals within care plan & liaise with GP and multidisciplinary teams
Refer to ICP and other specialists as needed

Patient-centred, outcome focused reviews

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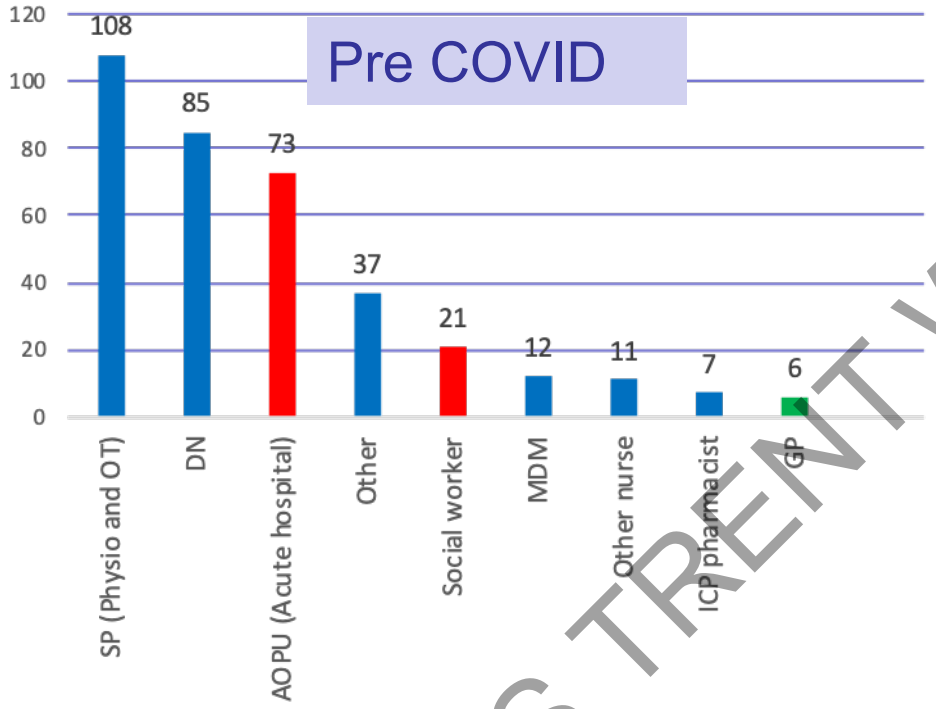
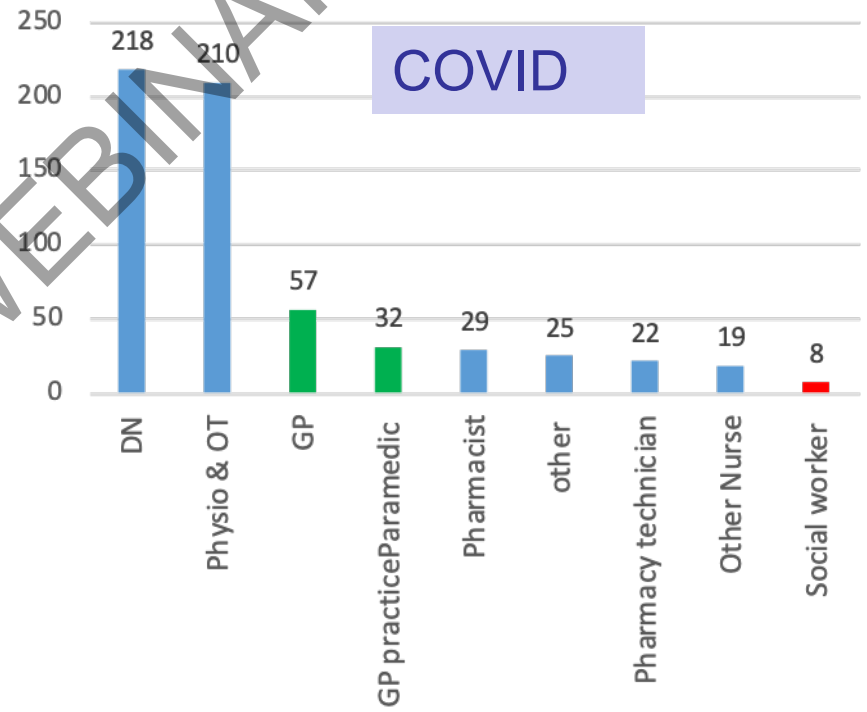
Changes during COVID-19 : Patient facing role

- **Stopped all face to face visits unless compelling reasons (~20%)**
  - Remote consultations (mostly telephone vs video)
  - Joint remote consultations with health and social care staff
- **Focus on managing immediate risks and essential medicines needs (do no harm)**
  - Symptom control
  - Safety/ reducing immediate/urgent medicines related harm (MRH)
  - Deprescribing if immediate harm, short-term wellbeing (safety vs numbers)
  - Medicines reconciliation and supply issues esp. during ToC
  - Reducing infection spread reducing dosing frequency (insulin) and facilitating self administration

Patient Referral to ICP team

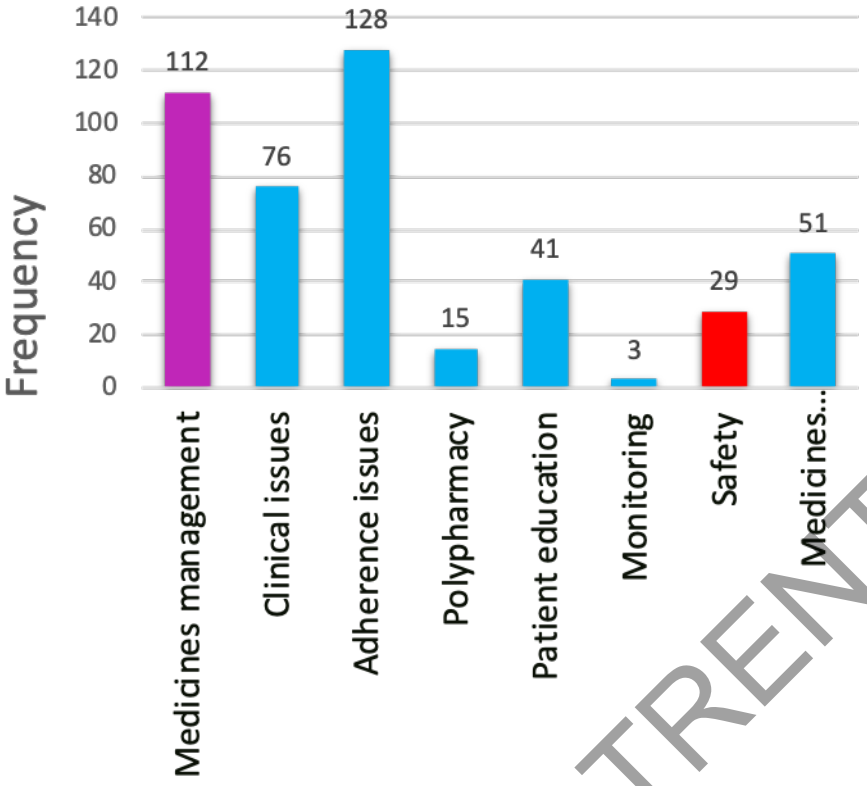
	Pre COVID (Apr- July 2019)	COVID 19 (April to July 2020)
Referrals	377	620
Average age	83	78



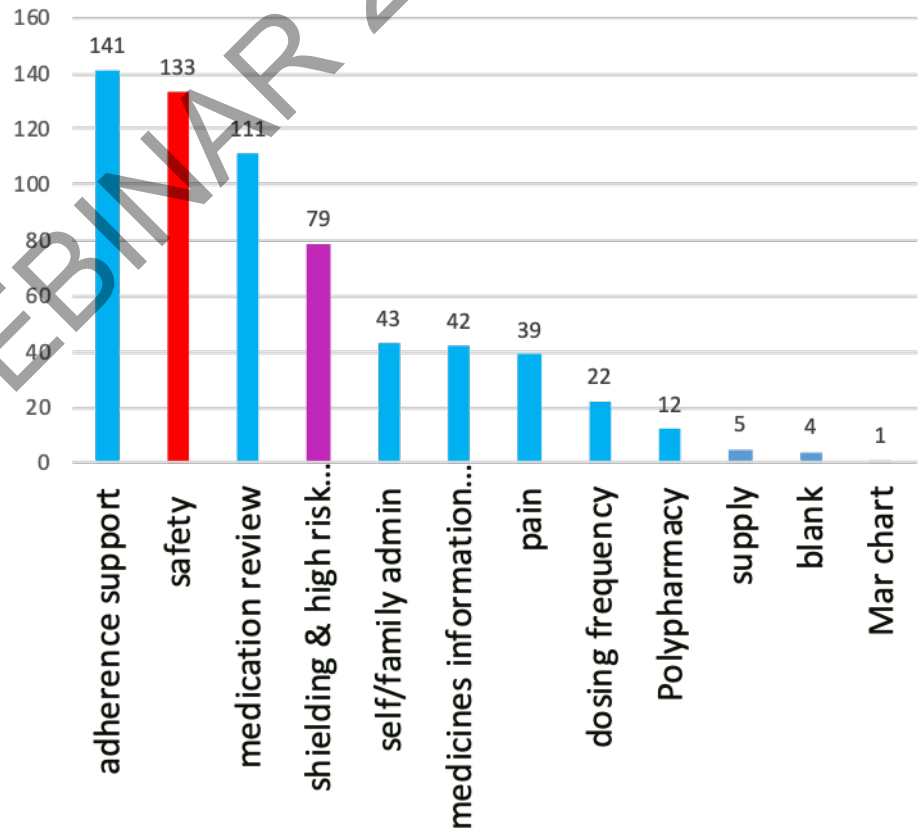


Reason for referral to ICP team

Pre-COVID n=455



COVID: n=632



Shielded group (n=31)

Mean age	• **73yrs**
Mean no medicines per patient	• 7.5
Stopped per patient	• 1.16
Average LTC per patient	• 9.12
Frailty	• Robust/mild, well supported at home, can use telephone consultation
Interventions	• Medicines management 'tidying up', deprescribing, dosing frequency, MI , start • @ least 1 follow up call post consultation

Remote consultations

Positive experience and opportunities

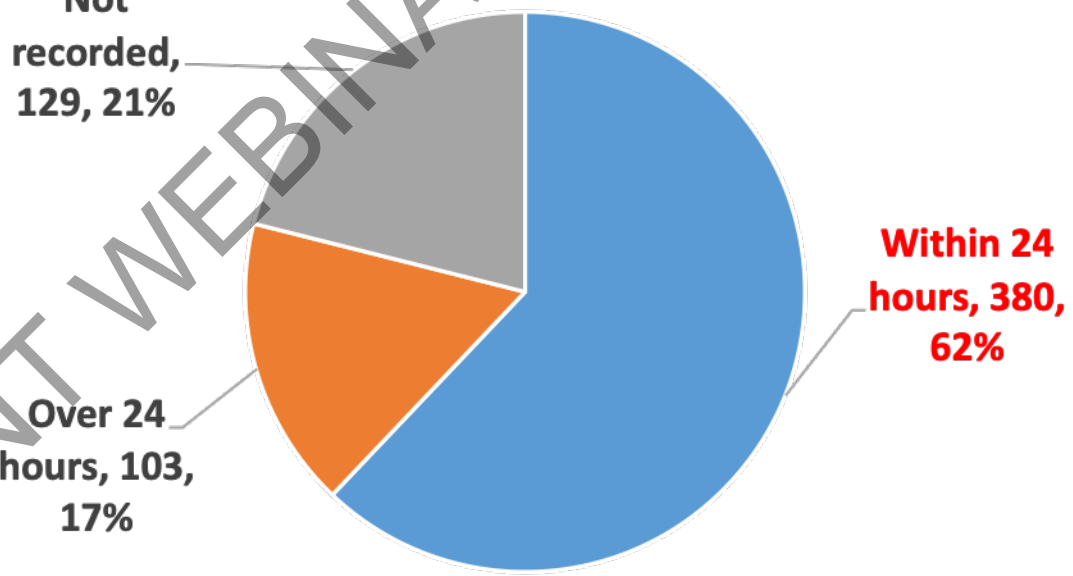
- More efficient pathway
- Creatively involve family and carers - more interactions, feedback with monitoring, supporting medicines administration
- Opportunity to utilise/involve other staff already visiting the patients where face to face is necessary e.g. BP monitoring, Obs
- Save on travel time-more consultations, flexibility with visit times
- Positive feedback from housebound and shielded patients that 'care is still been provided' without the risks of transmitting virus
- Can do consultations at base with full access to notes (2 screens) EPR, LCR etc vs on laptops in patient's home
- Surprised! some older people already using devices such as Ipads to communicate with relatives and health monitoring devices

Time from referral to first patient contact

Pre COVID

- 24 hours to 2 weeks
- Each sub team managing own referrals

COVID



Remote consultations: Challenges

- Mod to severe frailty except extra 3rd party support ⇨ Patients who cant speak clearly over the phone or are muddled, have cognitive impairment
- Teaching and support with complex techniques e.g using inhalers, insulin, processes involving multiple steps
- 'Blind spots', limitations and reliance on what patients say or not, non verbal cues, visibility re how patients interact with medicines at home (important in frailty)
- Hearing impairment ⇨ significant barrier and common
- Developing rapport and trust especially with new patients vs F2F
- Unable to resolve complex issues e.g. complex polypharmacy /adherence / errors in one go as patients easily overwhelmed vs F2F

Remote Consultation: Lessons learnt

Significant amount of pre-consultation preparation

- Understand the patient's social, functional and medical hx
- Get logistics right if 3rd party needed e.g agree convenient day/time for relatives/carers to be present
- Post/send reminder charts, simple PILs ahead to help with communication
- MAR charts needed in Care Homes re safety
- Need quiet room to have consultation in office space vs clinic room and IT failures- cutting out, voice fading in and out

Remote Consultation: Lessons learnt

Managing consultations to get best outcome

- Easier when a specific/identified problem (e.g supply issues, drug query/information) vs teasing out when risk is suspected, issue is unknown or complex
- Frequent shorter consultations vs longer F2F visit ⇨ f/up with text messages/ telephone etc to summarise discussions, action & changes
- Short consultation to broach/discuss need for change and give time to consider opinions vs two F2F visits
- Hypervigilance and safety netting vital ⇨ More cautious re deprescribing and prescribing changes as monitoring is limited
- Must have escalation process in place if F2F consultation is needed

Impact on future practice

- Prioritisation: Use the person's preferences, medicines safety and efficacy profile to prioritise the issues to be discussed
- One size doesn't fit all ⇨ need a range of options/solutions that can be tailored to the individual patient need.
- More collaboration with other staff already visiting the person routinely to undertake tasks that require F2F contact may be necessary e.g. observations to assess risks/ benefits of medicines. ⇨ additional work.
- Higher risks and uncertainties about benefits and harm of medicines ⇨ need wider MDT support, patient engagement and shared decisions
- New staff – unfamiliar with context of work e.g care homes

Changes in non-patient facing role (training)

- Significant increase for medicines training and competency sign-offs to increase capacity to safely undertake medicines related tasks (redeployed & existing staff)
  - Nurses : refresher on medicines reconciliation and meds admin processes in community
  - Therapists: medicines screening and assessment as part of holistic assessment post discharge, medicines reconciliation
  - Care workers medicines administration
- Shift from face to face medicines training
  - F2F with social distancing
  - Simulated scenarios vs F2F visits
  - Online and virtual classroom module developed

Changes in non-patient facing role: MDT collaboration)

Shift from Face to face to remote MDTs

- MDMs and safety briefing
- Remote advice/support – reduced visibility – reduced referrals/queries
- Proactive daily/weekly calls
- MDT working across health, social care (joint visit and feedback)

Now what?

- 4th year pharmacy student to analyse data
- Discuss and make recommendations for future practice
- Medicines optimization in frailty s everybody's business
  - Increase capacity (2nd wave) by upskilling PCN/GP pharmacists
  - Upskill health and social care staff to deliver medicines optimisation within their scope of practice
  - Building on current patient, family and carers engagement

Uncertainties

- Impact of back log of vulnerable, isolated who are less health seeking ?non-adherence/'self deprescribing' and safety issues
- New staff not familiar with set-up, time to build relationships via remote working

Summary

- Remote consultations can deliver medicines optimization
- Robust, mild > moderate to severe frailty (except with extra support)
- MDT vs silo working needed
- Opportunity to develop new effective communication and referral pathways
- Greater role for remote education and learning
- Successes may be based on existing MDT:MDT and MDT: patient relationships
- Long term effect on Pharmacy staff

Thank You for listening

Questions?