The Impact and Interventions of a Frailty Pharmacist within Emergency Department Frailty Team of an Acute NHS Hospital Trust

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tell them 10/10!

service was wonderful

you seem to be interested in me

...been listened to

Patient Feedback, ED

Background

Older patients admitted to the emergency department (ED) and reviewed by the frailty team do not routinely have a pharmacist-led medication review as part of the comprehensive geriatric assessment (CGA)- despite the presenting complaint often being attributed to overprescribing and problematic polypharmacy. Taking ten or more medications increases the risk of hospital admission by 300% due to adverse drug reactions (1); a medication review can reduce this outcome by optimising current therapy (2). Responsibility of safely transferring this medication information between care settings is a healthcare professional's duty yet the rate of error is 30 - 70% (3).

Aims

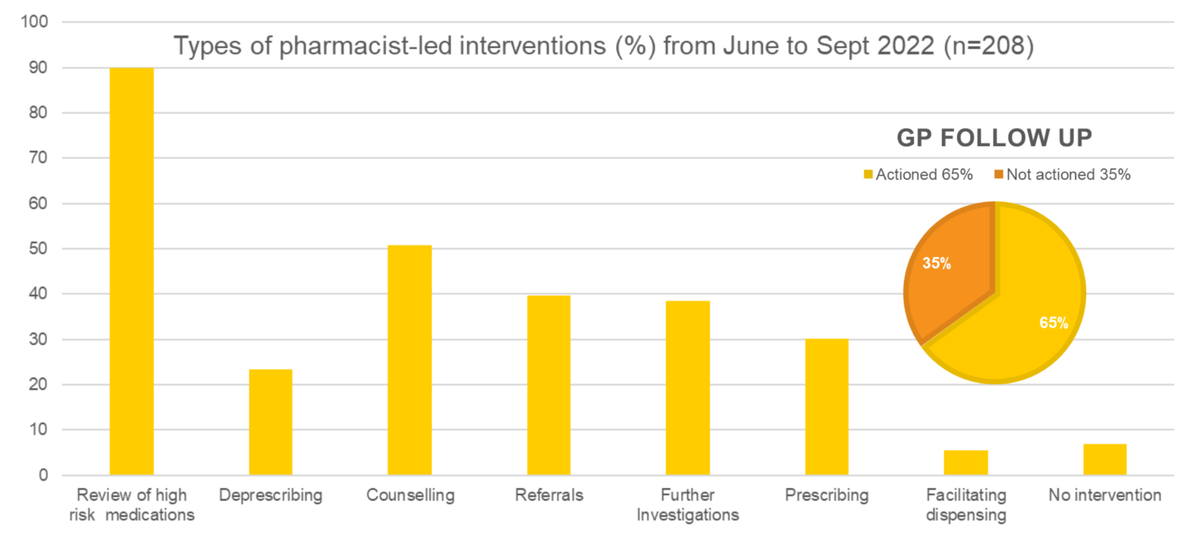
- Perform a pharmacist-led review and optimisation of medications for patients identified by the ED Frailty Team.
- Complete a pharmacist-led GP Plan to ensure transfer of care, where appropriate.
- Review if pharmacy GP plans were received and actioned accordingly.

Methodology

Patients were identified by the ED Frailty Team according to local frailty criteria: patients > 65 years presenting with delirium, a fall and/or multi-morbidities. Once the patient was deemed medically fit for discharge by the medical team, the patient had a full CGA from the frailty team. A pharmacist-led medication review was performed including reconciliation and optimisation (with investigations requested when required) with aim to reducing future harm/adverse outcomes. Medications were prescribed and/or supplied where appropriate. Interventions were categorised according to subtype. A GP plan was written to the Primary Care provider for electronic transfer of information; each patient being followed up after 4 weeks to assess if it had been received and actioned appropriately (consent having been sought during admission).

Results

92% of patients required a pharmaceutical intervention



Discussion

Strengths

- Patients were consulted within a fit-for-purpose Frailty Assessment Area (FAA) by the frailty MDT once they were deemed medically fit for discharge
- A medication review and optimisation plan allowed the opportunity to prevent future admissions, and patients were advised directly of any immediate recommended actions (e.g. stopping a medication)
- Stock was procured for use in FAA to allow timely administration of drugs to aid therapy assessments, avoid delayed administration of critical medicines, prevent avoidable deterioration in health, avoid hospital admission and discharge delays
- Having pharmacist prescribers ensured medications could be prescribed and/or dispensed in a prompt manner
- Further investigations such as lying/standing blood pressure were requested to allow medication assessment
- Patients and/or their family/carers were counselled directly to ensure that outstanding actions were highlighted and concerns addressed
- Pressure relieved from medical staff as drug reviews were led by skilled medicines experts

Limitations

- Not all surgeries were actively updating or checking discharge letters from ED; some GP plans were not even acknowledged
- Some GP plans were acknowledged but it was unclear changes had been actioned/ planned to be actioned upon
- Challenging to action immediate medication changes for patients with multi-dose systems (MDS) from an ED setting
- Additional funding required to provide frailty pharmacist cover 7 days per week in ED

Suggestions

- GP practices with poor follow up rates could be contacted to highlight awareness of GP Plan and ED discharge letter
- Use data to extrapolate saved bed days as evidence to support a business case for a full MDT FAA 7 day service

Conclusion

The pharmacist's input as part of the frailty MDT ensured the patient had a holistic and full CGA completed during their admission to the Emergency Department.

ED frailty pharmacist's input reduced inappropriate polypharmacy and optimised medication for this patient cohort, with majority of care plans followed-up appropriately post discharge.

A future study could examine re-admission rates of patients in comparison to those without a frailty pharmacist's input within a 6 month period.

References

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