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Bridging the gap between primary and secondary care of the elderly

By **Gareth Malson**, MRPharmS

Annett Blochberger is a former hospital pharmacist, now working at Nightingale House in Wandsworth, the UK's largest nursing home. This article outlines the benefits, challenges and tasks involved in working as a pharmacist in this setting

CHRISTIAN SCHMERMER

Annett Blochberger (right) works alongside other health care professionals

Over the past decade, medicines management has been a key development for hospital pharmacy departments in terms of improving safety and rationalising the supply of medicines in secondary care. Residents of nursing homes can be seen as having similar pharmaceutical care requirements to patients in hospitals, since they constitute concentrated populations of old and infirm patients, who are often prescribed large numbers of medicines. However, a nursing home will typically run with minimal or no pharmacy presence.

Nightingale House in Wandsworth is the UK's largest nursing home with a capacity for 250 patients. It is a charity that receives medical cover from Wandsworth Primary Care Trust by way of five part-time GPs and two nurse practitioners. In February 2007, Annett Blochberger, a former hospital pharmacist, was employed to improve medication safety and streamline drug expenditure.

With full access to medical records, and the authority to produce prescriptions for countersigning by GPs, she has already demonstrated the benefit of pharmacy input by reducing drug spending by 11 per cent.

Gareth Malson is staff editor of *Hospital Pharmacist*

Current duties

Ms Blochberger's routine activities can be divided up as follows:

- Generating prescriptions
- Liaising with secondary care staff regarding discharge prescriptions
- Monitoring stock
- Performing medication reviews
- Providing information and training

Generating prescriptions The majority of prescriptions are monthly repeats of medicines for chronic conditions. Producing these is particularly time consuming. In addition, prescriptions for dressings, nutritional feeds and stock drugs such as non-medical creams need to be furnished. Ms Blochberger has been given access to the GP computer system, and is able to produce prescriptions for the doctors to sign, before they are sent to a community pharmacy for dispensing.

Liaising with secondary care As may be expected in a nursing home, patients are constantly going to and from hospital. On starting her job, Ms Blochberger was surprised to see how little integration there was between primary and secondary care, and how little information was supplied on hospital discharge letters. She remarked: "It is not always easy to determine whether a discrepancy between medication lists on admission and discharge is deliberate or accidental." Also, the time taken to receive discharge information can be problematic. She explained: "Sometimes, a discharge summary is not received for up to three days after the patient leaves hospital. Previously in these situations, the nursing staff simply reverted to the previous medication list without checking whether any changes had been made."

This no longer occurs at Nightingale House thanks to the pharmacy intervention. Ms Blochberger liaises with hospital pharmacists when any patient is discharged back to Nightingale House, to ensure the correct information is passed on and all discrepancies are accounted for.

Monitoring stock A mundane, yet essential component of the job is stock monitoring. This includes rotating stock to minimise the amount that expires, and ensuring it is stored under the correct conditions. All stock requests from nursing staff need to be checked to see whether they are actually needed.

Medication review A full drug history is conducted for all patients admitted to Nightingale House and all medication administration records are reviewed at least monthly. In addition, a basic clinical check is undertaken for all new medicines, to assess

Panel 1: The Liverpool Care Pathway

The Liverpool Care Pathway is a multiprofessional, evidence-based framework for dealing with patients who are dying of any cause.

Drug related interventions include:

- Discontinuing non-essential medicines
- Prescribing subcutaneous medicines for symptomatic relief of recognised end-of-life problems when required
- Setting up a syringe driver within four hours of a doctor's order

dose appropriateness, identify contraindications and duplication of therapy, and prevent potential interactions with the patient's current medicines.

Providing information and training It is a Commission for Social Care Inspection (CSCI) requirement that all nursing staff receive training on medicines administration. Ms Blochberger provides monthly training sessions covering topics such as side effects, interactions, storage conditions, administration techniques and formulations. In addition, she provides information on administration of medicines via percutaneous endoscopic gastrostomy (PEG) tubes, as well as answering any other queries that doctors, nurses or patients may have.

Financial benefit

The key incentive for hiring a pharmacist to work at Nightingale House was to improve the home's CSCI rating for managing patients' medication. However, the PCT also wanted to save money by reducing waste, and therefore provide half the funding for the pharmacist post.

In the first quarter since Ms Blochberger was employed the total drug spend was reduced by 11 per cent. If continued, this will translate into an annual reduction in drug spending from £231,000 to £205,000. The majority of these savings are the result of simple streamlining measures and rationalisation, and Ms Blochberger is confident that there are further savings to be made.

"Careers" articles
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One example of rational cost-cutting involves the prescribing of nutritional supplements. Previously, these were prescribed for individual patients, and if the patient died or a supplement was no longer tolerated, the supplement was discarded. Now, the supplements are ordered in bulk. This requires some monitoring of stock levels, but has proved to make a large saving.

Another intervention involves liaising with secondary care regarding which medicines to supply on discharge. Generally, when a patient is discharged back to a nursing home, a hospital pharmacy need only supply medicines that the patient was started on in hospital. Further supplies of medicines that were unchanged during a hospital stay are typically discarded, because the nursing home already has its own supply. By liaising with the discharging pharmacist before the patient leaves hospital, Ms Blochberger is able to prevent the hospital pharmacy from wasting staff time and resources.

Requirements for the role

Ms Blochberger believes that a hospital background is beneficial for working in a nursing home, as it provides a different perspective towards medication checking that complements the work done by the community pharmacist when dispensing the medication. Also, a hospital background provides awareness of whom to contact to resolve various issues.

Ms Blochberger emphasised that she did not believe the role could be completed remotely (eg, by a community pharmacist on a sessional basis), due to the amount of work required to do the job thoroughly.

Clinical involvement

The post was originally offered with an element of clinical involvement. One area that had been identified internally for improvement was the need to implement a palliative care pathway. Ms Blochberger is involved in implementing the Liverpool Care Pathway (see Panel 1) for end of life care, and maintaining a stock of the necessary medicines. She has also developed guidelines for dealing with hypoglycaemia.

Due to time constraints, Ms Blochberger has been unable to fulfil the clinical role as fully as she would have liked. Therefore, she has prepared and submitted a business case for the employment of a pharmacy technician, to undertake a number of non-clinical tasks which would allow her to develop her role.

Challenges

Persuading the nursing home to get a technician on board has been the biggest challenge. Although the business case was submitted soon after Ms Blochberger started, the nursing home has been reluctant to take it forward because of an initial lack of understanding of the role of a clinical pharmacist. She expects to have a technician in place by April next year, in order to secure funding from the PCT.

Ms Blochberger says she has always enjoyed working as part of a team, so was initially worried that she might not enjoy the potential isolation of working as a sole pharmacist. However, she has regular contact with former colleagues and networks with other health care professionals, community pharmacists and PCT staff.

Future development

Once a pharmacy technician is hired and trained, Ms Blochberger hopes to expand her clinical role. She is starting an independent prescribing course in February next year, and is planning to develop her role into the following areas:

- Participating on GP ward rounds
- Completing level 2 and 3 medication reviews (see Panel 2)
- Expanding clinical monitoring
- Prescribing for pain management
- Prescribing suitable constipation treatment to reduce morbidity and mortality
- Monitoring anticoagulation
- Reviewing patients for risk of falls to prevent hospital admissions

Ms Blochberger is convinced that although it makes sense to employ a pharmacist at Nightingale House because of its large capacity, there is a place for a pharmacist at every nursing home to improve medication safety and reduce drug costs. She suggested that it is the responsibility of the GPs and PCTs that are commissioning new services to decide how best to employ them.

Panel 2: Medication review

In 2002, the National Prescribing Centre and Taskforce on Medicines Partnership produced a document entitled "Room for review", proposing that medication reviews can be carried out at the following levels:

- Level 0 — An unstructured, opportunistic review of a patient's treatment, often initiated by a query
- Level 1— A technical review of a list of patients' medicines
- Level 2 — A review of medicines with reference to full clinical notes
- Level 3 — A review of medicines and conditions conducted face to face with the patient