

# Crisis management: a day in the life of a pharmacist

*Pam Grant is the pharmacist with a community-based intermediate care team. She accepts referrals from other health professionals and social services care managers. Her goal is to identify — and implement — enduring solutions for patients who are unable to self-medicate. She also provides pharmaceutical education and training for other health professionals. Here she describes a day in her life...*

## **8.45am**

The day starts with a visit to a patient who is registered blind, a known alcoholic, and recently discharged from hospital. Medicines include lansoprazole, mirtazepine, risperidone, standard multivitamins and a reducing dose of chlordiazepoxide.

This referral has come from the hospital discharge technician who, having packed the prescribed medicines in a blister pack on discharge, was concerned for the patient's safety if he starts drinking again at home. My previous visit had established that the patient had been drinking heavily.

In consultation with the consultant psychiatrist, the patient's GP and his care manager, it was agreed to simplify his regimen to essential medicines only, and organise a morning visit from home care. His medical therapy is reduced to lansoprazole, for severe indigestion, and risperidone as a single morning dose to control agitation. The care manager agrees to consider increasing the package of care, with a view to ultimately obtaining a placement in a care home.

The patient's son, who was present during both my visits, explains that his father has received all the appropriate counselling about his lifestyle but has chosen not to listen.

## **9.30am**

Call in to the nearest community pharmacy to arrange continued supply of medicines for this patient in a seven-day blister pack for weekly collection by the home care worker.

## **10.00am**

Tutorial session with the nurse consultant on our team, who is undergoing nurse prescribing training. We work through a few of her competencies together, and I suggest examples of commonly encountered drug interactions and serious adverse drug reactions for her to look out for on the wards. We fix a date for her to spend a Saturday morning dispensing alongside me in a community pharmacy. This will give her an appreciation for the practical aspects of medicines taking. I hope she will see how difficult and confusing it can be for our elderly patient group to self-medicate from user-unfriendly blister packs.

## **10.45am**

Time for my monthly personal development review (PDR) with my clinical supervisor who is the nurse specialist on the team. We discuss my case load and agree that it is becoming unmanageable. She will speak to the intermediate care manager about recruiting a dispensing technician to help perform some tasks such as organising scrips for patients and collecting medicines from community pharmacies and filling compliance packs in patients' homes. This will free up my time for more domiciliary patient assessments and reduce my waiting list.

We design a brief pro-forma about medication compliance problems for community nurses to use. We hope to collect quantitative evidence that many patients in the community have

problems of manual dexterity, visual impairment or cognitive loss and consequently are just not able to medicate safely. We will disseminate this request for information to the nurses via the PCT modern matrons.

## **11.30am**

I receive a phone call from a patient's GP to say that, as we suspected, her phenytoin plasma levels are too high and the dose must be reduced immediately. She is helped to take her dose of phenytoin liquid at around 6.00pm by rehabilitation home carers. After a quick calculation, I agree the new dose with the GP, phone the care agency to make certain that the home carers know about the change of dose, and visit the patient's home to change the pharmaceutical part of the care plan. I also phone the community pharmacist, who supplies other medicines for this patient in a weekly blister pack. This will ensure that the correct dosing instructions accompany the next phenytoin supply. Phone my next patient to let them know I will be delayed, and reschedule the visit.

## **12.05pm**

I visit a patient who is registered blind and has to use three different types of eye drops. She also takes a number of cardiovascular medicines. Her cognitive function is good and she has developed several coping strategies enabling compliance with therapy.

However she now struggles to medicate safely due to problems with generic medicines. She does not receive the same brand of eye drops or oral medicines each month and is getting confused when tablets and packs vary in shape, size, or colour. We agree that she could benefit from having her medicines supplied in a

weekly blister pack by her local pharmacy. The pharmacy will also re-order her medicines for her, as she is no longer able to tick the surgery order form. I have arranged with her surgery to change her timolol eye drops to the brand Timoptol which she finds easier to distinguish from her pilocarpine. (Timoptol is actually cheaper than timolol so this also helped the GP prescribing budget!) I show her how to use an opticare device, which enables her to apply her eye drops more accurately.

### 12.50pm

On leaving the block of flats, I see my next patient being wheeled towards an ambulance. I speak to the paramedic and give him a list of the currently prescribed medicines, with a note to let the hospital know that the patient had not been medicating recently due to increasing memory loss.

The purpose of my visit had been to initiate a seven-day compliance pack for essential cardiovascular medicines. The reason for admission was dehydration and poor nutrition, despite an intensive home care package.

Unfortunately this patient was no longer motivated to eat or drink and the GP decided to admit her. It is likely that she will be discharged to residential care.

### 1.00pm

I call in to a pharmacy which has agreed to take on the supply and pharmaceutical care for a number of patients I have recently referred to them.

I discuss individual cases with the technician responsible and give her details of medicines, dosing times, start dates and collection days.

She also requests names and contact phone numbers for GPs, care managers and community psychiatric nurses. Each patient is allocated a claim number so that in future there will be an audit trail for payments claimed.

### 1.45pm

Back to the office for a quick bite of lunch whilst updating patient details on my laptop. I use an Excel spreadsheet to keep track of patients' problems and pharmacist interventions. It also accumulates cost savings to prescribing due to changes in medication resulting from therapeutic review. The computer calculates ongoing annual cost for patients initiated on monitored dosage systems (MDS). The profit to the project is currently running at about £8,000 pa. This is based purely on savings to prescribing costs, but does not take account of hospital admission prevention or savings in home care costs.

### 3.00pm

Just in time to speak about my role to a group of people from the community who care for patients with Parkinson's disease (PD). The talk is followed by a wide-ranging discussion about how impossible it is for some PD patients to self-medicate without carer support. I stress the importance of timing of doses and the PD nurse specialist comments on difficulties in getting nurses on the ward to administer doses when they are needed by the patient, rather than at prefixed times. There are lots of grumbles about how user-unfriendly surgery repeat re-order forms are. Lack of synchronisation of quantities means frequent unnecessary visits to the surgery. Some surgeries do not remove old medicines from the repeat forms regularly and the carers admit to having ordered old medicines by mistake. I encourage them to change the quantities on the re-order forms themselves and to inform the surgeries promptly about any medicines no longer needed. Before I leave, I give them all a hand-held medication record card for them to list their patient's current medicines. I urge them to keep the record up to date and tell them to take it with them to all hospital outpatient appointments.

### 4.15pm

There is a message on my mobile from the hospital anticoagulation clinic to say that the INR result for one of my patients is too high. Warfarin must be stopped for three days and re-initiated at a lower dose. Home carers prompt this patient to medicate and her warfarin dose is due at 5.00pm. There is just time to prevent today's dose being taken. I arrive at the patient's flat to find her sitting with her feet up, totally oblivious of any risk, sipping a gin and tonic! (Could this explain the INR result?) I remove three day's warfarin from the blister pack and re-pack the remaining medication with a lowered warfarin dose. I phone the surgery to arrange for another blood test to be done in five days time when another dosage adjustment may be needed.

### 5.00pm

As I am about to leave for home, I receive a call from one of the community mental health team to say that a patient with Alzheimer's is having trouble sleeping since starting a course of donepezil. We agree to try a donepezil-free week before considering a trial of galantamine or even memantine. This patient lives by herself, is currently without need of personal care and the agreed goal is to maintain her safely in her own home for as long as possible. I look at my watch and decide that this patient visit must wait for tomorrow....

*Pam Grant works for the Woodlands Elderly Resource Team, Poole Primary Care Trust*

### Your life in a day

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