

# Work of a falls prevention pharmacist

Pharmacists can reduce the risk of falls among elderly patients through a variety of interventions, says **Jeremy Robson**

**P**harmacists can play a key role in preventing falls by conducting medication reviews assessing patients' medication needs. I have been involved in developing this work at Leeds Teaching Hospitals NHS Trust since 2003, when the trust received funding for the expansion of its orthopaedic services. My post as interface pharmacist for elderly medicine and orthopaedic surgery was introduced to provide medication reviews on the orthopaedic elderly care ward rounds and a pharmacist presence at the twice weekly multidisciplinary fall clinics.

The post was established as part of a strategy for implementing the sixth National Service Framework for Older People (2001), which states that action should be taken to prevent falls or reduce resultant fractures and other injuries.

My role is integral to the specialised multidisciplinary team. I provide input from the falls clinic on ward rounds and cover clinical areas such as acute stroke and orthopaedics.

The medication reviews at the clinic are often incomplete because I do not have access to GP records, or visit patients at home. When this happens I have to give advice and make decisions based on incomplete drug histories.

I am working to develop good lines of communication and to share information with my primary care colleagues. For example, I forward my medication review form with the consultant's letter so it can be recorded in the patient record in primary care.

Ideally there would be no disconnect between the service the patient receives in hospital and that in the community. Next year I hope to launch a research project to track patients after discharge to see whether GPs prescribe medicines, such as bisphosphonates, that have been identified as necessary by the hospital falls team. This would be part of a DPharm.

I am a supplementary prescriber and was hoping to do some prescribing of bisphospho-



nates, but these medicines are classed as GP medicines and not part of urgent care. We can only prescribe things that are clinically urgent.

There is great scope for pharmacists to help in preventing falls: even simple interventions are likely to have an impact on patient care. My role is constantly evolving.

I oversee the more complex patients, from either a medical standpoint or that of the social issues around discharge from hospital. It is important to get the medication right and find out how patients take it.

My typical week begins when I prepare for the first falls prevention clinic at Chapel Allerton Hospital in Leeds on Monday morning. A weekly clinic has been running there for four years but new funding means the clinic can be held twice a week and we hope to make it five times a week.

I liaise with nursing staff at the clinic to decide who are the priority patients. Interventions need to be individualised and this has meant that different health care disciplines need to collaborate.

I ensure that each patient has a complete drug history, including over-the-counter and herbal drugs. I confirm what drugs the patient is taking and establish which medicines have been started or discontinued in the past six months. This information is looked at in conjunction with the patient's falls history to see if there is a correlation.

I conduct a medication review using the information I have available, including medical notes, primary care information, what the patient says and referral letters. A full medication review would require access to other sources such as GP records and it should be conducted in the patient's home.

We encourage patients to bring their medicines to the clinic, but this rarely happens. I am looking at improving this element of our work by introducing home visits and by improving collaboration with primary care.

A practice pharmacist has accompanied me at some of the falls clinics and that showed there is some duplication of work. This is something we could tackle if we had electronic patient records and could record the medicines and treatments given irrespective of whether in primary or secondary care.

I ensure that patients are prescribed "bone prophylaxis" in the form of calcium (1g) and vitamin D (800 units) supplementation with or without a bisphosphonate, in accordance with guidelines from the National Institute for Health and Clinical Excellence. Calcium and vitamin D<sub>3</sub> are not generally pre-

scribed unless the patient has had a previous fracture or been diagnosed with osteopenia or osteoporosis.

My ward commitments include an orthopaedic surgical ward and a medicine for the elderly ward (acute stroke ward). On Tuesdays and Thursdays I attend the medicine for the elderly liaison consultant ward rounds on the orthopaedic wards. We usually see patients over 80 years old with fractures — generally hip fractures — who have unresolved medical and social problems.

I conduct a medication review with the consultant, deal with compliance issues and advise on bone prophylaxis. In the past a pharmacist would not have conducted the falls medication review. The trust has three designated orthopaedic elderly medicine wards. Elderly fracture patients are admitted under a care of the elderly medicine consultant, with the orthopaedic surgeon visiting to resolve orthopaedic problems. The pharmacy team conduct in-depth medication reviews and has a supplementary prescribing role.

My role is an integral part of a specialised multidisciplinary team. This has helped me to appreciate the different skills of other professionals and I enjoy the fact that we are working together for the benefit of the patient. I also enjoy having a specialist role that is varied.

Our approach at Leeds has attracted the attention of other hospitals which are working towards setting up something similar.

## My career

Thinking of changing your career? This series profiles different careers in pharmacy. It is designed to provide a taster of work in different specialties. Any pharmacist who would like to contribute to the series should contact the editorial office on 020 7572 2429 or e-mail editor@pharmj.org.uk in the first instance.

## Jeremy Robson's CV

**January 2005 to date** Interface pharmacist for elderly medicine and orthopaedic surgery at Leeds Teaching Hospitals NHS Trust (LTH)

**2003–05** Rotational pharmacist (elderly and respiratory medicine) at LTH. Studied for the doctor of pharmacy at Bradford University, developing as a specialist practitioner through reflective practice

**2002–03** Medicines management pharmacist at Rotherham General Hospital

**1999–2002** Resident pharmacist at Doncaster and Bassetlaw NHS Trust

**Graduated in 1999** from Bradford University