TAKING PHARMACY OUTSIDE THE PHARMACY

Doctors and nurses are not the only professionals carrying out home visits to patients in the community. Helena Stimpson is a pharmacist who conducts medication reviews with patients in their homes. She describes her role

Helena Stimpson is a clinical medication review pharmacist at South Downs Health NHS Trust

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It is not for everyone but I really enjoy visiting patients at home to review their medication. I work as a clinical medication review pharmacist in Brighton and Hove in East Sussex. Since January 2007 I have been setting up the medication review service for South Downs Health (a community NHS trust that provides community, specialist and rehabilitation services by employing district nurses, community matrons [advanced nurses who case-manage patients], heart failure nurses and phlebotomists, etc). As the only clinical pharmacist in the trust it is a challenge (we also have a chief pharmacist who is involved in helping to improve medicines management and safety) but it is also exciting to be paving the way for pharmacy services within the trust.

Process

So, how does it work? I take referrals from community matrons for their new patients and other patients that have medication issues. Once I make an appointment to see the patient I collect information on them, ie, a medication list and medical history summary from the GP surgery, plus any useful information from the matron notes such as clinical observations, specialist assessments and health and social issues relevant to the patient. I also have access to pathology results online, which is really useful.

I then go through each drug the patient is on and assess the indication, dose, frequency, possible adverse effects and interactions, contraindications, effectiveness, monitoring required and whether it is based on evidence, ie, whether it adheres to local and national prescribing guidelines. This can take 20 minutes to two hours, depending on the number of medicines they are on. When preparation is completed I hit the road and visit the patients. I work with a total of 16 GP surgeries around the city (basically these are the surgeries that the matrons work with). Due to preparation time, travelling, seeing the patients and writing up the visits, I am able to manage approximately two patients a day. Sometimes I also pop into the patient's pharmacy or GP surgery to gather more information, or to speak to the doctor or pharmacist.

At the visit I spend up to an hour talking to the patient about his or her medicines. I get a full drug history, including over-the-counter medicines and allergies, and I also assess compliance. I ask questions related to what I have identified in my preparation, eg, possible side effects, efficacy (such as pain control), and I also give the patient a chance to ask questions. I try not to be too prescriptive in my approach so that patients have a chance to talk freely rather than feel like they are being interrogated. Having said that once I have heard all about the grandchildren, seen the wedding photos and had a tour of the newly installed bathroom, I try to steer them back on track to their medicines.

Our trust uses single assessment process (SAP) folders and documentation so I make sure to leave a record of my visit in the folder, including my contact details. I write a summary of the visit highlighting any issues that I will be following up with the GP or pharmacy or other relevant person, so that the patient is aware of any suggested changes to their medication. If patients wish I also supply a list of their medicines including indications and doses. The drawback of this is that we do not know at that stage if the GP will agree to and action these suggestions.

Following the visit I write a report stating my recommendations and include a full medicines list established from the visit. This is sent to the GP, community pharmacy and community matron for their information and action, if appropriate. If I identify compliance issues I liaise with the community pharmacy to see how it can help. Alternatively I can refer them to the service in the city, "Take as directed", which provides home visits to patients and offers a compliance-aid service with three levels, according to the patient's need, eg, a medication chart or blister packs.

The main objective of my service is to reduce unplanned hospital admissions due to medication issues. Some examples of issues I have identified that I think would have caused a hospital admission are described in the Panel.

Working with nurses

This job has given me an interesting perspective on healthcare as I'm no longer working as part of a pharmacy team and work predominantly with

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nurses. It can be a bit professionally isolating so I try to make sure that I keep up to date with my CPD by attending local Centre for Pharmacy Postgraduate Education talks and pharmacy study days. I also go to regular clinical meetings at the local hospital pharmacy and receive monthly bulletins from the pharmacy prescribing advisers at the primary care trust.

How did I get into medication review?

My background is as a hospital pharmacist and I think it really helps to have the clinical knowledge and experience that comes from this. I also spent a couple of years as a hospital pharmacist in Australia, including seven months as a medication review (outreach) pharmacist. This involved visiting patients at home within seven days of discharge to review their medication and compliance, and communicating any medication changes that had occurred in hospital to the GP.
As part of this role I worked with a multidisciplinary case management team doing medication reviews for their patients. Medication review is a bit more established in Australia and in fact it is mainly community pharmacists who do these reviews. There was a whole local network established in Melbourne for pharmacists to receive training and support to do reviews in the community.

The future

So far I have seen about 130 patients and believe that I have prevented 14 hospital admissions. I have now expanded the service to include referrals directly from GPs for any patients registered at the 16 surgeries that I cover. Future referral sources could include district nurses, specialist nurses (eg, heart failure and respiratory), the local intermediate care service and community pharmacists. If funding is provided we could also set up a hospital discharge medication review service, helping to bridge the gap between primary and secondary care. This would enable me to see patients at a time when changes to their medication frequently raise issues and concerns for both the patient and the GP. ■

Issues I identified that I think would have caused a hospital admission

1. A patient was discharged from hospital following a bleed on warfarin. The warfarin had been stopped and the patient had been advised to restart in a few days following discharge and then have an international normalised ratio (INR) test. I visited the patient and found that he had restarted the warfarin immediately on discharge and was taking 3mg tablets instead of 1mg. I removed the 3mg tablets to avoid further confusion and contacted the GP, who arranged for an INR test that day.

2. I discovered that a patient who had been prescribed indometacin suppositories for pain relief was also taking ibuprofen bought over the counter. I advised this patient not to take ibuprofen but to use paracetamol instead.

***3.** A patient was on long-term diclofenac but the proton-pump inhibitor had been stopped by mistake. The GP then restarted lansoprazole.*