**Utilising the skills of the clinical pharmacist within the MDT for improved medicines optimisation**

Key Highlights

The Carter Report

* Recommended that Trusts should ensure more clinical pharmacy staff are deployed
* Working more closely with patients, doctors, nursing staff and independently
	+ To deliver optimal use of medicines
	+ Make informed medicines choices
	+ Secure better value
	+ Drive better patient outcomes
	+ Contribute to delivering 7 day health and care services.

**The aim of the project**

The aim of this project was to change the way in which the pharmacists work, to integrate them in to the multi-disciplinary team and to ensure medicines optimisation for patients at the earliest opportunity.

Clinical pharmacists are a useful members of the multidisciplinary team and are responsible for ensuring the prescribing of medications is appropriate, complies with local and national guidelines and above all, safe. The most common interventions made on the surgical wards revolve around the prescribing of venous thromboembolism prophylaxis and antibiotic prescribing. Integrating the pharmacists in to the daily ward rounds with the surgical team was hoped to improve compliance for prescribing against the relevant guidelines in these areas.

The hope was that the presence of the pharmacist would ensure prescribing of medications was correct and appropriate within the first few hours of the patient’s hospital admission. Also, where Independent Prescribing (IP) pharmacists were able to attend the ward round they could facilitate a timely discharge from hospital through the prescribing of discharge medications at the end of the ward round.

* A pharmacist attended the Monday and Friday PTWR 03rd July -6th Nov 2017
	+ A pharmacist was available to attend 30 of the 37 PTWR’s that took place between these dates
	+ Non-attendance was due to lack of staff availability (sickness, staffing pressures, AL)

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| --- | --- |
| Total number of patients seen on 30 PTWR | 492 |
| Total number of interventions | 625 |
| Interventions per patient | 1.3 |

**Antibiotic Interventions**

* Total number = 105
* Main interventions include;
	+ Review to stop antibiotics
	+ Prescribing of gentamicin to AMG protocol for intra-abdominal sepsis
	+ Switch from IV to PO

Significant interventions

* Patient treated for abdominal sepsis but no signs of infection. On teic and metro. Stopped all antibiotics
* On one round three patients on abdominal sepsis treatment but not prescribed gent. Gentamicin added and discussed with team the importance of gent to ensure adequate cover
* Patient complaining metronidazole upsetting her orally so was given intravenous broad spectrum antibiotics. Actually patient’s oral antibiotics were prescribed 8 hourly and she had had a dose given at 2am on an empty stomach which would have caused the nausea. Suggested rather than changing regime to change schedule and counselled patient to take with food
* Pt admitted with hiatus hernia. She mentioned having a cough on round and was diagnosed with suspected CAP. Consultant wanted to prescribe Amoxicillin but the pharmacist pointed out a penicillin allergy and recommended an alternative regimen

**VTE Interventions**

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| --- | --- |
| Total number of interventions relating to VTE | 86 |
| VTE Risk assessment prompt | 35 |
| VTE Prophylaxis initiated | 42 |
| VTE dose adjustment | 9 |

Significant interventions

* Patient due for discharge who had not received their usual warfarin during admission. Medicines reconciliation completed. Discussion with anticoagulation clinic regarding appropriate dose for discharge and plans for INR check in community. All completed by the pharmacist to prevent delay for discharge.
* Patient diagnosed with bilateral pulmonary embolisms. Dose of VTE treatment too low for patient weight. Changed by the pharmacist.
* Patient admitted with rectal bleed. Usually takes warfarin for metallic heart valve. In a&ethe patient had been review by a Haematology Consultant who wanted warfarin to continue alongside tranexamic acid. During the ward round the pharmacist notices the warfarin had not been prescribed for the previous 48 hours. Drug history completed. Warfarin added to drug chart. The pharmacist advised team to contact haematology with regards to cover until INR back in range. The junior doctor contacted haematology and patient was prescribed an Iron infusion and a higher dose of VTE prophylaxis.

**Pharmacist Interventions**

* Ensure safety and improve quality and continuity of care
* Demonstrates the role of the pharmacist’s professional input into the multidisciplinary team
* Allows for a critical review of prescribing for newly admitted patients
* Allows for monitoring of near-misses in relation to the prescribing and administration of medications

**Moving Forward**

* PTWRs are being rolled out across both sites at WSHT in to other acute inpatient areas.
* We have increased the number of prescribing pharmacists within the Trust to increase the number of significant interventions possible on ward rounds and improve the timeliness of interventions.

**Data Collection Form**

