An audit to review how patients manage with their medicines at home following a hospice inpatient stay

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Introduction

Research identifies that when patients move between care providers, the risk of miscommunication and unintended changes to medicines is significant. Adverse drug reactions occur in up to 20% of patients after discharge following an acute admission, with the risk of an adverse drug reaction increasing by 4.4% with each drug alteration. Approximately 5% of hospital admissions are medicines related.

We wanted to look at hospice ward discharges to see if our patients were similarly vulnerable.

Aims

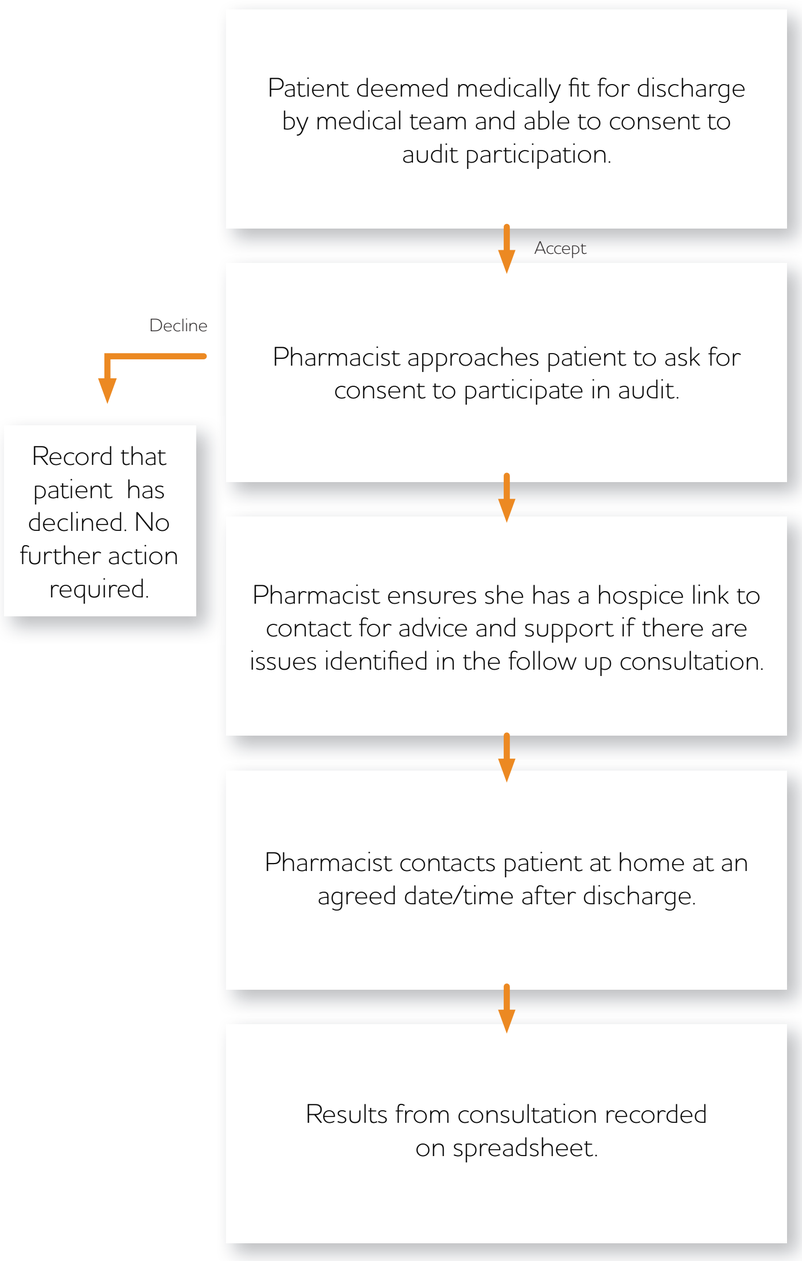
To identify whether, and if yes, what difficulties are faced by patients with their medicines post discharge from the hospice.

To improve the quality of discharges within the organisation.

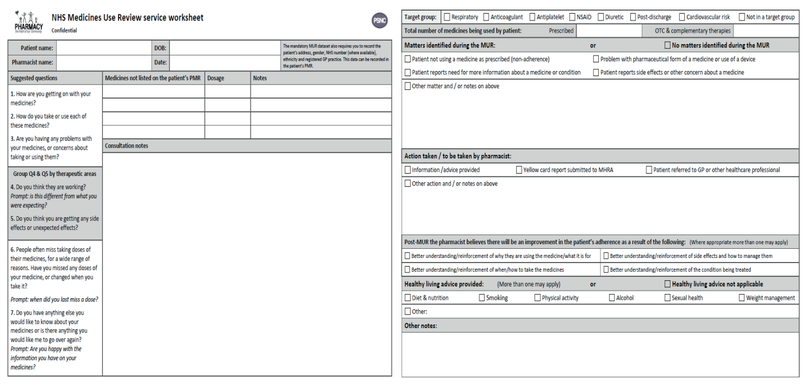
Objectives

- To contact patients after discharge from a hospice stay to find out whether they had been managing their medicines.
- To check if patients received written instructions on taking their medication. Also verbal information about indication for use, benefits and potential harms as per the hospice Medicines Management Policy.
- To understand some of the difficulties faced by hospice patients with managing medicines after discharge.
- To identify whether patients are compliant with their medication after they leave the hospice.

Method



Data Collection



NHS Medicines Use Review service worksheet
Confidential

PSNC

Patient name:	DOB:
Pharmacist name:	Date:

The mandatory MUR dataset also requires you to record the patient's address, gender, NHS number (where available), ethnicity and registered GP practice. This data can be recorded in the patient's PMR.

Suggested questions	Medicines not listed on the patient's PMR	Dosage	Notes
1. How are you getting on with your medicines?			
2. How do you take or use each of these medicines?			
3. Are you having any problems with your medicines, or concerns about taking or using them?			
	Consultation notes		
Group Q4 & Q5 by therapeutic areas			
4. Do you think they are working? *Prompt: is this different from what you were expecting?*			
5. Do you think you are getting any side effects or unexpected effects?			
6. People often miss taking doses of their medicines, for a wide range of reasons. Have you missed any doses of your medicine, or changed when you take it? *Prompt: when did you last miss a dose?*			
7. Do you have anything else you would like to know about your medicines or is there anything you would like me to go over again? *Prompt: Are you happy with the information you have on your medicines?*			

Target group: ☐ Respiratory ☐ Anticoagulant ☐ Antiplatelet ☐ NSAID ☐ Diuretic ☐ Post-discharge ☐ Cardiovascular risk ☐ Not in a target group

Total number of medicines being used by patient: Prescribed | OTC & complementary therapies

Matters identified during the MUR: or ☐ **No matters identified during the MUR**

☐ Patient not using a medicine as prescribed (non-adherence)
☐ Problem with pharmaceutical form of a medicine or use of a device
☐ Patient reports need for more information about a medicine or condition
☐ Patient reports side effects or other concern about a medicine
☐ Other matter and / or notes on above

Action taken / to be taken by pharmacist:

☐ Information /advice provided ☐ Yellow card report submitted to MHRA ☐ Patient referred to GP or other healthcare professional
☐ Other action and / or notes on above

Post-MUR the pharmacist believes there will be an improvement in the patient's adherence as a result of the following: (Where appropriate more than one may apply)

☐ Better understanding/reinforcement of why they are using the medicine/what it is for
☐ Better understanding/reinforcement of side effects and how to manage them
☐ Better understanding/reinforcement of when/how to take the medicines
☐ Better understanding/reinforcement of the condition being treated

Healthy living advice provided: (More than one may apply) or ☐ **Healthy living advice not applicable**

☐ Diet & nutrition ☐ Smoking ☐ Physical activity ☐ Alcohol ☐ Sexual health ☐ Weight management
☐ Other:

Other notes:

- Consecutive patients successfully contacted two weeks after discharge from the hospice, up to a maximum of 20 patients.
- Data was collected by the hospice pharmacist using the same form which community pharmacists utilise to complete medicines use reviews.
- An additional data collection form was also designed to capture information that the medicines use review form does not capture.

Result

20 patients were followed up and interviewed.

Criterion	Standard	Result
Patients leaving the hospice ward should be able to manage their medicines at home.	100%	100%
Patients leaving the hospice with capacity should understand the indication for each of their medicines.	100%	**90%**
Patients should take their medicines as directed.	100%	**70%**
Patients discharged from the hospice ward should receive verbal and written information about their medicines as per Medicines Management Policy.	100%	**95%**

Note: 40% of patients were discharged with blister pack medication.

Reasons why patients did not take their medicines as directed

1. 5% of patients completely stopped taking their medicines as they felt too tired.
2. 5% of patients experienced a side effect from a particular medicine and hence stopped taking the medicine.
3. 15% of patients stopped taking a drug as they did not feel that the drug was working.
4. 15% of patients have difficulties obtaining medicines from their community pharmacy which resulted in patients missing their medicines.
5. Some patients increased/decreased medicine frequency without medical advice.
6. Blister packs on discharge did not improve compliance.

Note: for some patients more than one reason applied.

Our Learning

- This audit highlights some difficulties experienced by patients with their medication despite good verbal and written information at discharge.
- Community pharmacists are not routinely informed when changes have been made to a patient's medication. This can cause problems when they are filling the blister pack. In our small study, 40% of patients were discharged home with a blister pack. 25% incorrectly refilled the blister pack after their supply from the hospice had run out.
- Medicines prescribed on the hospice ward can be quite specialised and not kept as stock in the community pharmacy. This caused delays in some patients receiving critical medicine such as analgesics.
- We found that GPs and pharmacists made changes on repeat prescriptions/dispensing which we attribute to lack of understanding about intent of medicines
  e.g. Vitamin C effervescent for tongue furring changed to regular tablets;
  maintenance steroid stopped;
  steroid doses divided and spread through day
- Patients are highly liable to change or adjust medicines themselves.

Limitations

- This pilot audit was carried out with a small sample of discharged patients from one hospice ward.
- A larger sample size is needed in order to ascertain applicability of findings to other hospices.

Suggestions for Improvement

- A copy list of discharge drugs should be sent to the community pharmacy with a pharmaceutical care plan.
- Patients leaving the hospice with a drug that might be hard to find should be made aware and given a list of chemists known to be familiar with palliative medication.
- The ward needs to know what might be hard to obtain. We could work with our CCGs on training opportunities for community pharmacists and GPs about palliative care medicines.
- Discharge paperwork should be clear about intent for ongoing medicines.

References

1. Royal Pharmaceutical Society (2012) Keeping patients safe when they transfer between care providers – getting the medicines right.

2. Leendertse A et al. (2012) Frequency and risk factors for preventable medication-related hospital admissions. Arch Int Med; 168(17): 1890-1896.

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