Admission Avoidance Schemes
Intravenous Drug Administration in the Community
A Survey of Current Provision

The DH Transforming Community Services Programme was launched in 2010 and all organisations began looking at different ways to provide services in a more cost effective manner. The transformational guides that accompany the Programme cover six areas, one of which is Transforming Services for Acute Care Closer to Home. The delivery of Intravenous (IV) therapy within the community is one of the 'high impact changes' that the guide suggests as an innovative service that organisations might consider setting up.

It is well known that the risks of errors associated with prescribing, preparing and administering injectable medicines is higher than for other forms of medicines. The NPSA alert 20 - Promoting safer use of injectable medicines recommended a number of actions to be taken to improve medication safety and reduce the number of medication errors involving injectable medicines. In addition wrongly prepared high-risk injectable medication is now a Never Event. It is vital that the risks associated with delivering an intravenous service are addressed and safe, robust care pathways are set up.

Within the East and South East England geography we were aware that a number of organisations have set up care pathways to administer IV in community services. As there are a number of issues to address when setting up such a scheme we were sure that many different models of care pathway had emerged. We were keen to find out more about these different care pathways, acknowledging that there is not a right or wrong model but different models. We wanted to see what influenced these different models and to gather practical solutions to the issues.

Background

Setting up an IV service within the community is not a straightforward process and there are a number of issues to address when setting up an IV service in the community.

- **Referral process**

  It is important to have a referral process which defines whether patients will be taken from acute trusts (step down) and/or referred from primary care (step up) as both of these care pathways may result in different models of care e.g. who holds medical responsibility; where supplies come from.

- **Medical responsibility**

  It is vital that medical responsibility is determined before a patient is admitted onto the care pathway. It is important that the medical practitioner is aware of their responsibility to provide this care and has the necessary competencies to do so. If the on-going medical responsibility is with the acute trust doctor, it may be difficult for them to review the patient. If the medical responsibility is with the GP there may be concerns about caring for patients who have traditionally been admitted to an acute setting.

- **Prescribing responsibility**

  It is important that this is defined in the care pathway and whilst this is usually part of the medical responsibility it is not always so. A non medical prescriber may have this responsibility or the prescriber may be a different doctor to the one who has medical responsibility.

- **Supply of medicines**

  The drugs used in IV services are widely available from hospital pharmacies but in contrast they are not routinely stocked by community pharmacies. Some IV drugs are classified as 'hospital only lines' at wholesalers, which makes obtaining them harder for community pharmacies. As a

consequence timely supplies are often difficult to obtain within the community unless this has been addressed in the care pathway for example by setting up a local enhanced service with community pharmacies to stock the drugs.

- **Disposables**

The disposable consumables which are required to give IV drugs are not available on the Drug Tariff, so cannot be prescribed on NHS FP10 prescriptions. It is important that the sourcing and resourcing of these consumable items is identified within the service.

- **Information Sources**

Community IV schemes involve staff working in relative isolation so it is important that staff have access to appropriate information sources and know where to go for further information.

- **Policies**

Community IV schemes need to be supported by robust policies which define the duties and responsibilities of all practitioners.

Aims of the Survey

The aim of this survey was to explore the provision of intravenous medicines in community settings across the east and south-east of England

Method

All Community Health Service Pharmacist contacts on the London Pharmacy Education and Training contact database were emailed in January 2011 and invited to complete a simple questionnaire about IV drugs in the community (See Appendix 1). The contact database at the time represented the community provider services in the geography of the former 60 PCTs. Organisations were able to give more than one response to each question if appropriate.

Results and Discussion.

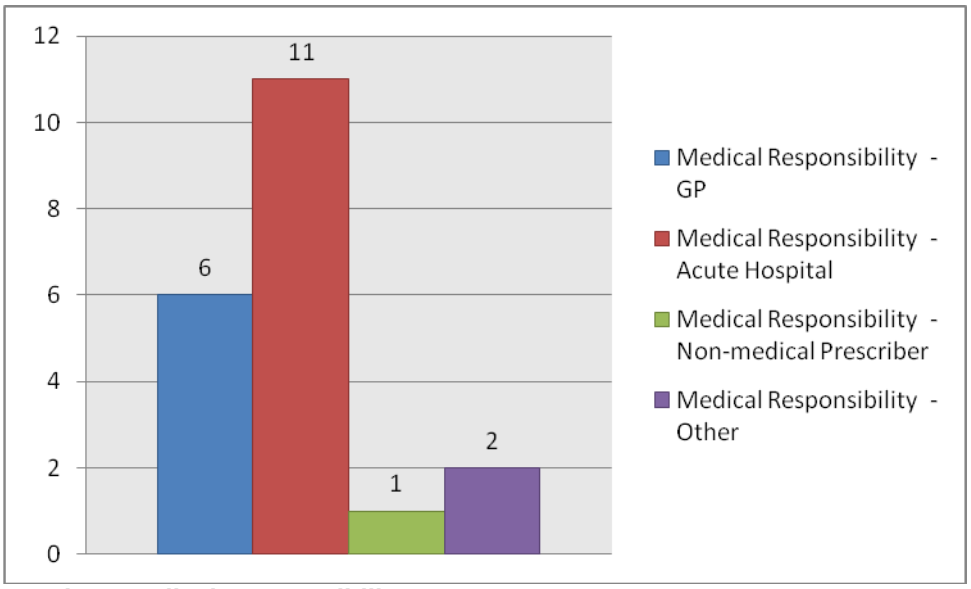
17 questionnaires were returned. Three indicated that there was currently no provision of IV therapy in the community. The following results are based on responses from 14 organisations. This survey was undertaken before the recent NHS organisational changes were finalised.

Referrals

All organisations that responded were receiving referrals from the acute trust and half were also receiving referrals from GPs. This shows that the majority of care pathways currently established are for step down services where patients continue their therapy after discharge. However, half of the respondents have set up step up services, where patients are referred by their GP without being admitted to an acute trust bed.

Medical Responsibility

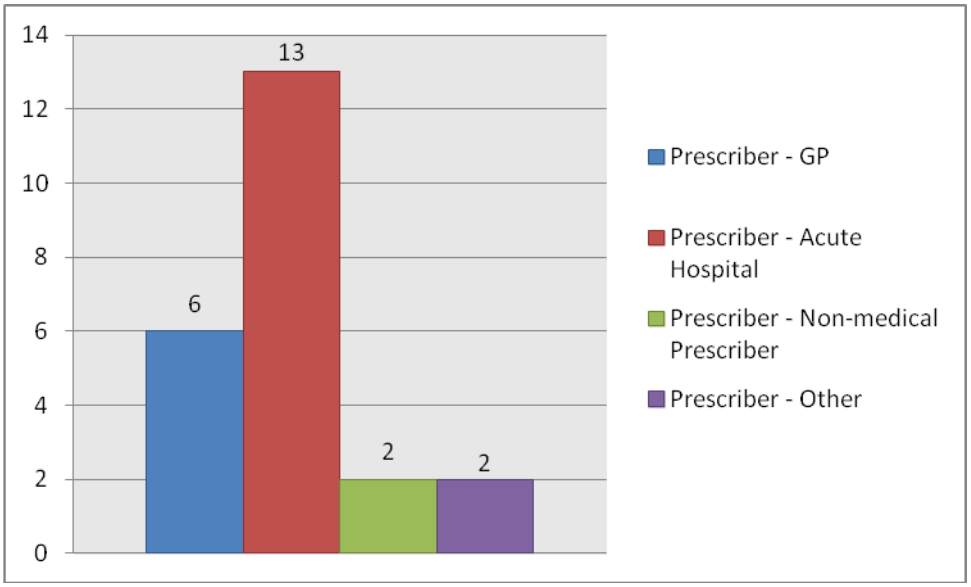
We have anecdotal evidence to suggest that in the past assigning medical responsibility has been a stumbling block for such schemes. Graph 1 shows the results for who took medical responsibility for the patient whilst receiving IV drugs in the community. The survey showed that in the majority of schemes the medical responsibility was held by a doctor in the acute trust. In some organisations the medical responsibility was with the GP, but this was dependent on the patient being a step up patient. One organisation had a care of the elderly consultant attached to the Rapid Response Team, and another organisation employed a consultant in primary care and these doctors took medical responsibility for patients receiving IV drugs in the community. One organisation indicated that the medical responsibility was sometimes held by a non medical prescriber.



Graph 1: Medical Responsibility

Prescriber

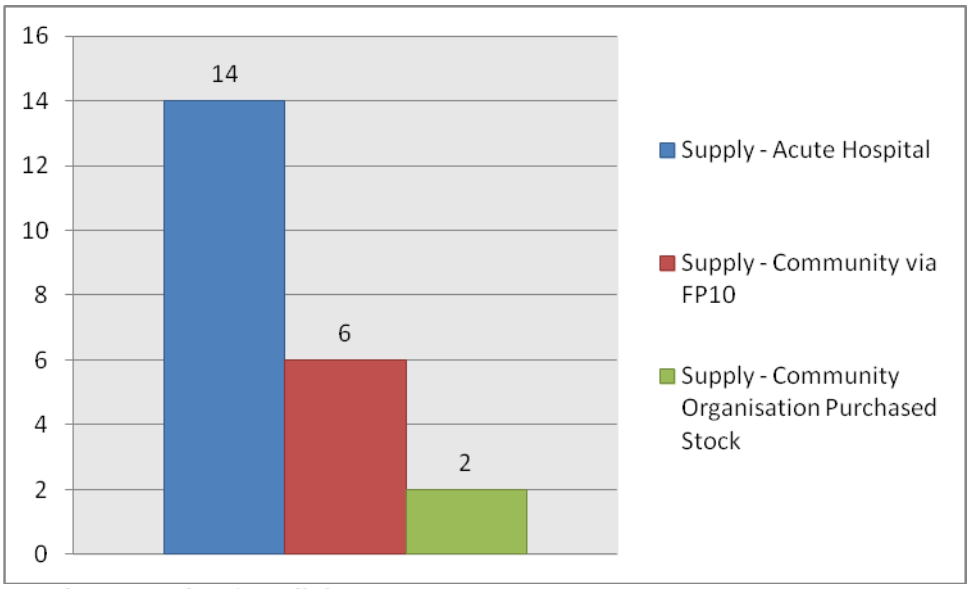
Graph 2 shows who prescribes for patients receiving IVs in the community. In the majority of cases the initiating prescriber was a doctor with the acute trust, and this reflects that most schemes involve the patient going to the acute trust to be assessed. It also reflects who has medical responsibility when the prescribing is initiated. The two organisations reporting the use of 'other' prescriber were consultants employed by the community organisation as described in 'medical responsibility'. The use of non medical prescribers was rarely reported and this could be an area of workforce development.



Graph 2: Prescribing Responsibility

Supply of Medicines

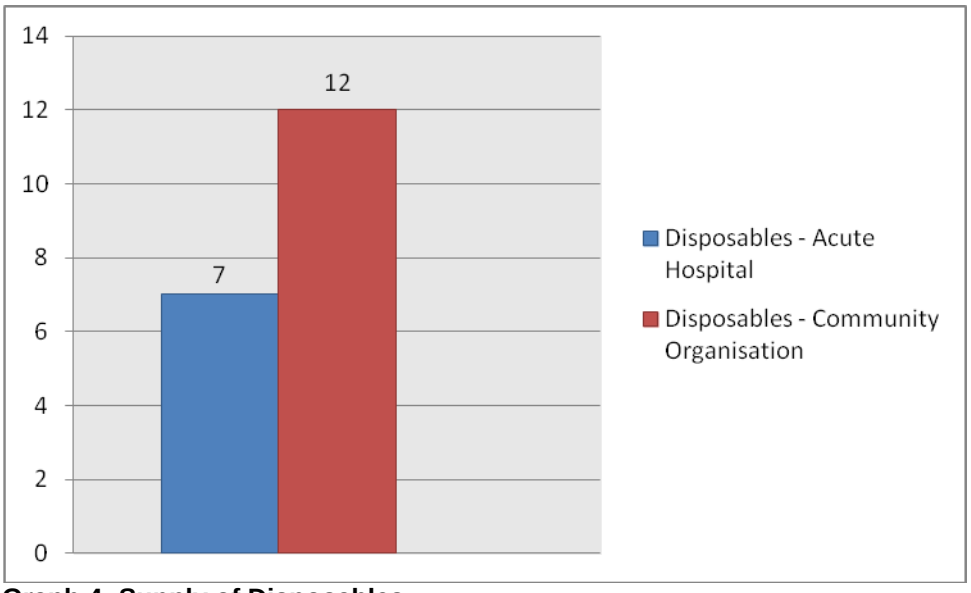
Where supplies of medicines were obtained from is shown in Graph 3. The majority of care pathways used the acute trust as the supplier of drugs. This was partly due to where the drugs were prescribed but also due to the availability of intravenous drugs. Most community pharmacies do not hold stocks of these drugs but one way of ensuring timely supplies of these drugs via community pharmacies would be to set up a local enhanced service with named community pharmacies to stock the drugs. Two community organisations purchased stock drugs for the care pathways. Some organisations had different supply routes for step down patients compared with step up patients.



Graph 3: Supply of Medicines

Disposables

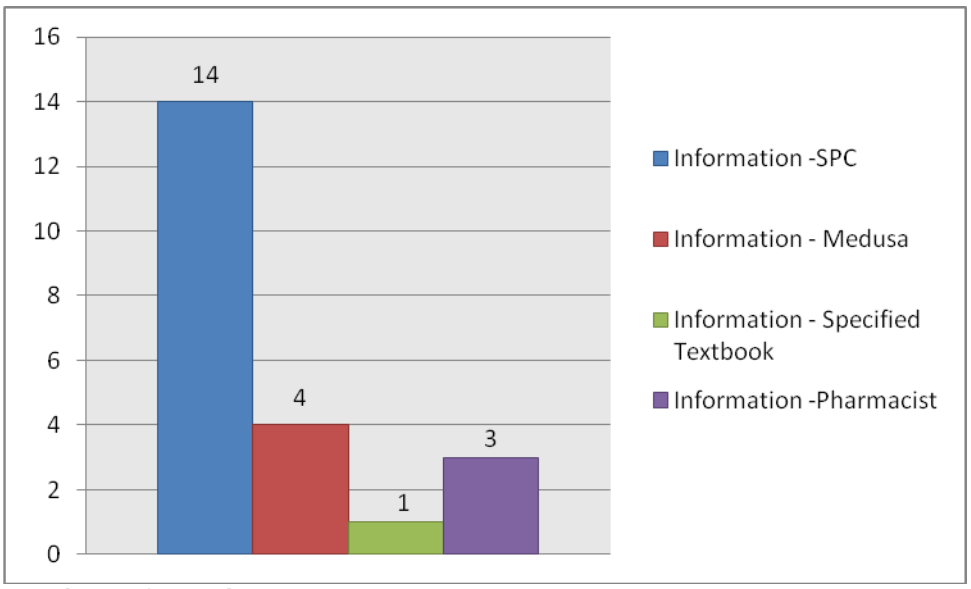
Many responders commented that access to supplies of disposable items that are required to administer intravenous drugs was often difficult to resolve. When the drugs were supplied from acute trusts the hospital pharmacy did not supply the administration sets. Similarly these items are not prescribable on an NHS FP10 prescription, so cannot be prescribed by a GP. In this survey the majority of supplies of disposable items came from the community organisation. The results are shown in Graph 4. Some responders commented that allocating budgets to this supply was difficult and often a stumbling block in the care pathway.



Graph 4: Supply of Disposables

Information Sources

Graph 4 shows that all organisations relied on the Summary of Product Characteristics as the main source of information for healthcare practitioners. Four organisations had invested in the Medusa online guide which is produced by a partnership between Imperial Trust and UKMi (http://www.injguide.nhs.uk)



Graph 4: Information Sources

Policies

Thirteen organisations had IV policies in place and the one remaining organisation was in the process of developing one. What was not clear was whether these policies were specific for the community organisation or whether the local acute trust policy had been adopted.

Recommendations

- It is clear from the survey that when intravenous drugs are administered in the community more than one care pathway may be needed depending on whether the patients are referred to the service from the acute trust or directly from GPs.
- It is important that when a community intravenous service is designed the medical responsibility is defined within the care pathway.
- Prescribing responsibility must be agreed within the care pathway. The use of non medical prescribers in this role may be an appropriate specialist role development for community nursing staff.
- The mechanisms for supply of medicines and disposable giving sets must be identified. This may involve allocating a budget.
- Nursing staff administering intravenous medicines in the community work in isolation and need to have clearly defined policies and procedures. In addition it is important that the staff have access to appropriate medicines information.
- The use of a limited formulary within the service will reduce the range of medicines used and may reduce the risks associated with administering an unfamiliar medicine.

Future Steps

This survey shows that there are a number of different care pathways that have been set up to deliver IVs to patients in the community. We suspect that these responses represent those organisations that have established intravenous services and are doing it well. As a result of this survey we decided to look at the safety standards of the administration of intravenous therapies and it is proposed to carry out a collaborative baseline audit of IVs in the community in Autumn 2011.

References

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Appendix 1
Admission Avoidance Schemes - IV drugs in the Community

Name		
Contact details		
Name of organisation		
Type of organisation		
Does your organisation administer IVs in the community?		
Are patients referred from the acute trust?		
Are patients referred by GPs?		
Who takes clinical medical responsibility for the Patients? Is this defined in the service specification?	GP	Y/N
	Hospital doctor	Y/N
	Non Medical Prescriber	Y/N
	Other, please describe	
Who prescribes for the patient?	GP	Y/N
	Hospital doctor	Y/N
	Non Medical Prescriber	Y/N
	Other, please describe	
Is there a formulary, or agreed list of drugs?		
Is there an IV Drug Policy?		
How are the drugs supplied?	From Acute Trust on Acute prescription	Y/N
	From Community Pharmacy on FP10	Y/N
	From stock held in community unit	Y/N
	Other - please describe	
Is a Pharmacist involved?		
If yes, are they able to advise on compatibility with concurrent medication?		
Where do the disposables come from and who pays for them?		
Is there a cold chain set up if the drug requires it?		
Do nurses administer the first dose in the community?		
Do nurses have access to information such as the SPC? If yes, please specify what information they have		