DEVELOPMENT OF A STROKE PATHWAY PHARMACY TEAM TO SUPPORT REABLEMENT AND MEDICATION OPTIMISATION

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Introduction

In Sheffield, the stroke pathway comprises the early days of admission up to discharge from the Community Stroke Service (CSS), which can be up to 3 months in duration. In line with the latest NICE recommendations and the updated British Association of Stroke Physicians’ stroke standards, patients who have had a stroke require pharmaceutical care as part of their multidisciplinary care throughout their time in the stroke pathway. Pharmacy teams in the acute unit and intermediate care services have inadequate resources to provide patient-centred care, resulting in delays or omissions in completing medicines reconciliation, starting medicines reablement, optimising medication and to ensuring consistency in the admission and discharge processes. This project was designed to pilot a new collaborative way of working to demonstrate the hypothesis that the earlier in the stroke pathway patients are reviewed by a clinical pharmacist, and the earlier reablement with medicines can commence – the better the outcome for patients.

Method

Patient recruitment

- Study period 1st June – 31st July 2015

139 patients screened
56 patient included
31 intervention
25 control

Intervention group criteria:
- Any patient with the potential for reablement with their medications (e.g. were independent with their medications prior to the stroke), identified prospectively by the pathway pharmacist and followed up by pharmacy staff throughout their journey on the stroke pathway from 1st June – 31st July.

Control group criteria:
- Any patient on the stroke pathway who received “standard” pharmacy input – ie. No reablement assessment.

Recruitment of patients and allocation to each arm of the study was based on the clinical review by the pathway pharmacists working on the wards for the interventions with hospital input or by the current process of referral from other health care professionals in the intermediate care team.

- Medicines reconciliation carried out as soon as possible in the patient pathway
- Medicines reablement began earlier in the pathway
- Medicines optimisation to limit care calls required to administer medication
- Database designed for transfer of information
- Both control and intervention groups were then followed up and monitored for changes in the number of calls required.

Conclusion

- NICE states that medicines reconciliation should be completed at each interface of care; ideally within 24 hours of arrival. The pathway project improved these figures significantly. 100% of patients had their medicines reconciled during the project period – two-thirds of which were completed within 24 hours of admission.
- Communication between care settings was supported by a specifically designed database.
- Two-thirds of patients in the study had medicines administration cut from care calls following pathway pharmacist intervention: 17 patients (31%) had medicines administration eliminated from their care packages which reduces length of stay and addresses the incidence of patients inappropriately allocated to the different parts of the stroke pathway due to delays.
- Although care calls are not always required exclusively to manage medication, the proportional amount of the call which did exclude medicines administration was calculated at about 1/3 of the time of the call (at least 10 minutes). This would mean that for every four patients that had medicines administration removed, the pathway pharmacy team would be reducing the length of stay of one patient in the acute trust.
- The pathway approach allowed the pharmacy team to review and reable more patients compared to what was achieved by each group in isolation. As figure [Fig 1] shows, proactive reablement screening must therefore be an essential function of the team, as this offers the flexibility required to respond to the changing needs of stroke patients.

References

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