Clinical pharmacist integration in home-nursing teams TO REDUCE MEDICATION RISK

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background

Older people receiving home-nursing care are at higher risk of medication-related problems and adverse medication events (AMEs) related to:

- unstructured home environment
- communication challenges
- multiple prescribers and pharmacies
- recent hospital discharge[1].

Bolton Clarke (formerly Royal District Nursing Service) is a large provider of home-nursing services across the Eastern Melbourne PHN catchment. Over 50 per cent of clients are referred for medicines administration or monitoring of medicines-taking.

the TEAMM-Pharmacist intervention

Eastern Melbourne PHN partnered with Bolton Clarke to trial an interdisciplinary workforce model that integrates the medication management skills of a clinical pharmacist within the home-nursing team – The **TEAMM**-(**T**imely **E**nhanced **A**ccess to **M**edication **M**anagement) **Pharmacist project**.

Client risk profile[2]

66% taking ⩾ 5 medicines

48% taking high risk medicines

40% transition from hospital

Problems for home-nurse

- **incomplete**, **unclear**, or **multiple** medication lists
- **uncertain** medication history
- medication **changes** post hospital discharge / specialist review
- **delays** in confirming reconciled medication list for administration
- **complex regimens** requiring multiple daily visits to individual clients

Clients with medication errors 40%

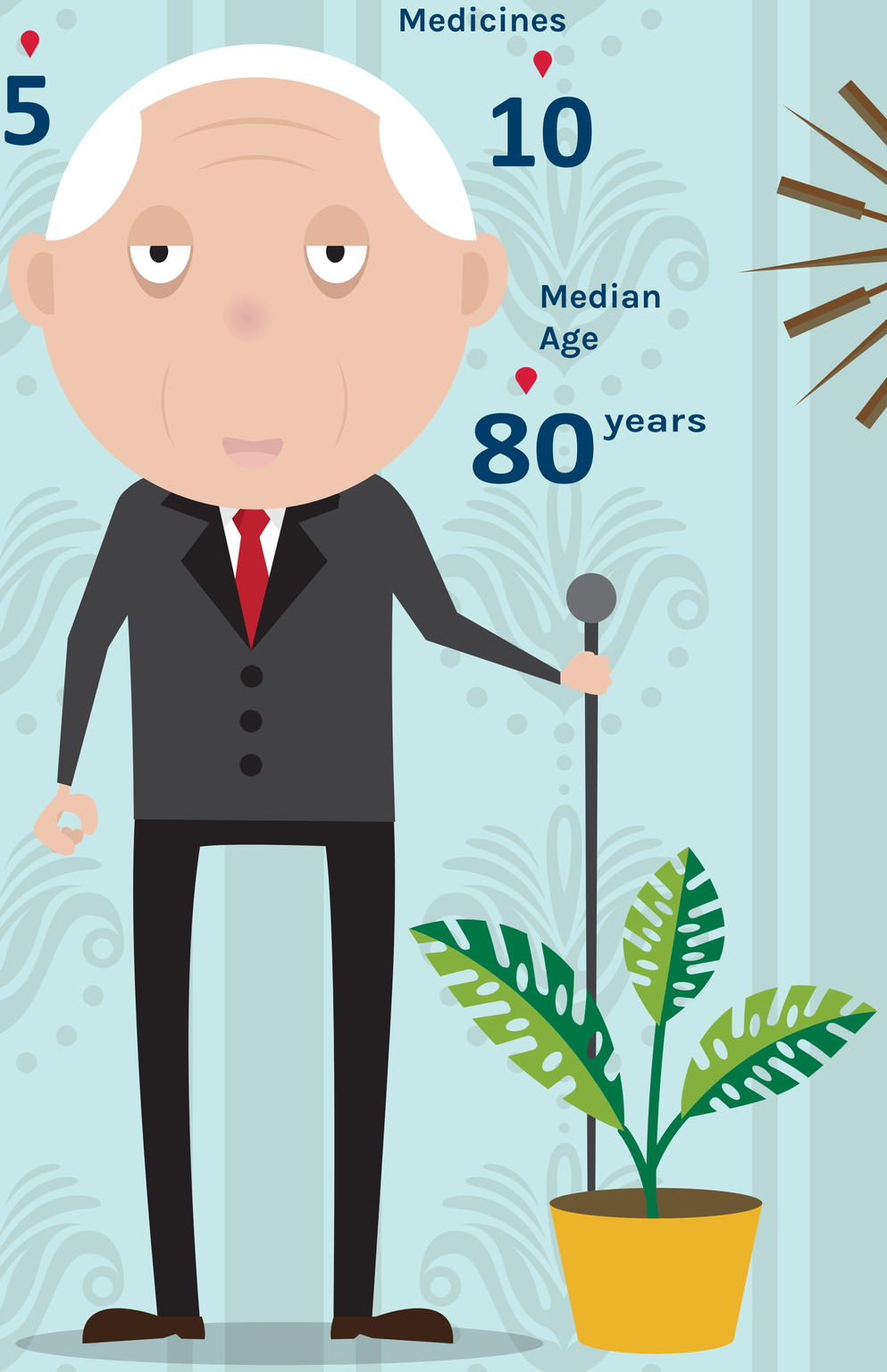
Clients with AMEs requiring hospitalisation or medical consultation 13%

AMEs are preventable 64%

Median Conditions **5**

Median Medicines **10**

Median Age **80** years



nurse

- identifies clients at risk of experiencing medication issues, problems and errors
- refers to TEAMM-Pharmacist
- arranges for joint visit

TEAMM-Pharmacist

- undertakes medicines review and makes recommendations for regimen simplification and optimisation
- creates a reconciled medication list for GP's approval and authorisation of nurse administration
- coordinates medication management with GP, nurse, hospital, specialists and pharmacy
- provides follow up to ensure resolution of medication issues

conclusion

Deployment of clinical pharmacist expertise for higher risk clients introduces a risk management strategy for avoiding AME and associated health care costs and client distress. Reconciliation and simplification of regimens contributes to improved workforce efficiency and productivity for nurses, and improves team-care and communication between healthcare providers.

1. Meyer-Massetti C, Meier CR, Guglielmo BJ. The scope of drug-related problems in the home care setting. *International Journal of Clinical Pharmacy*, 2017
2. Elliott RA, Lee CY, Beanland C, et al. Medicines management, medication errors and adverse medication events in older people referred to a community nursing service: a retrospective observational study. *Drugs-Real World Outcomes*, 2016, 3(1), p. 13-24.
3. Elliott RA, Lee CY, Beanland C, et al. Development of a clinical pharmacy model within an Australian home nursing service using co-creation and participatory action research: the Visiting Pharmacist (ViP) study. *BMJ Open*, 2017; 7:e018722. doi:10.1136/bmjopen-2017-018722

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