Collective MDT Work on The Frailty Unit

The Impact and Interventions of Frailty Pharmacists within the Emergency Department Frailty Team of an Acute NHS Hospital Trust

Background

Older patients admitted to the emergency department (ED) and reviewed by the frailty team do not routinely have a pharmacist-led medication review as part of the comprehensive geriatric assessment (CGA)- despite the presenting complaint often being attributed to overprescribing and problematic polypharmacy. Taking ten or more medications increases the risk of hospital admission by 300% due to adverse drug reactions (1); a medication review can reduce this outcome by optimising current therapy (2). Furthermore, the responsibility of safely transferring this medication information between care settings is a healthcare professional's duty yet the rate of error is 30 - 70% (3).

The pharmacist's input ensured the patient had a holistic CGA during their ED admission

What did the project involve?

Patients were identified by the ED Frailty Team according to local frailty criteria, including: patients >65 years presenting with delirium, a fall and/or multi-morbidities. Medicines reconciliation was carried out by the frailty pharmacist, and medications optimised to reduce future harm with investigations prompted where needed. Interventions were categorised. A summary plan was written to the General Practitioner (GP) and each patient was followed up after 4 weeks to assess if received and actioned appropriately.

Results

73 medication reviews were conducted for patients (mean age 84.4 years) from June to Sept 2022; majority presenting with fall (69%). High-risk medication review was most common intervention (90%), followed by counselling (50%). 92% of patients required a pharmaceutical intervention (n=208). GP plans were actioned for 65% patients in Primary Care.

Strengths

A medication review and optimisation plan allowed the opportunity to prevent future admissions.

Stock was procured to allow timely administration of drugs.

Having pharmacist prescribers ensured medications could be prescribed and/or dispensed in a prompt manner.

Further investigations such as lying/standing blood pressure were requested to allow medication assessment.

Pressure relieved from medical staff as drug reviews were led by skilled medicines experts.

Limitations

Not all surgeries were actively updating/checking ED discharge letters. Some GP plans were acknowledged but it was unclear if the advice was actioned.

Challenging to action immediate medication changes for patients with multi-dose systems (MDS) in ED setting

"Tell them 10/10! The service was wonderful. You seem to be interested in me and I have been listened to"

Patient, ED

Outcomes

The ED frailty pharmacist's input reduced inappropriate polypharmacy and optimised medication for this patient cohort, with the majority of care plans carried out appropriately following discharge.

Next steps

Ensure this pharmacy service is sustained in ED as staffing resources allow.

GP Practices with poor follow-up rates could be contacted to highlight awareness of the GP plans and ED discharge letters.

References

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