Clinical pharmacists in aged care

Improving quality use of medicines

Richard Thorpe
Accredited Pharmacist

Early beginnings

- Research project commissioned by Goodwin Aged Care in collaboration with University Canberra.
- Clinical pharmacist employed 2 days a week from April to October 2017.
- Based at Goodwin site David Harper House with a second Goodwin site used as a control.

Initial key findings

- Significant reduction in the proportion of inappropriate dosage forms.
- Reduction in medication round times.
- Adverse drug reactions and allergy reporting significantly improved.
- Mean monthly medication incident reports significantly improved.

Current practice

- Goodwin employed a full time Accredited Pharmacist to work across all residential sites (~280 beds) from December 2018.
- Position fund by Goodwin with RMMR remuneration.

Stakeholders comments

Pharmaceutical Society Australia

“Medicine-related harm in residential aged care facilities is an alarming issue – one which could be improved through embedding pharmacists in aged care.”

Society of Hospital Pharmacy Association

“High quality, embedded clinical pharmacy services for aged care residents and pharmacist-led medication management services are urgently needed to reduce alarmingly high rates of medication-related problems experienced by older Australians.”

The way forward

- Further two-year trial starting in 2020 in ACT.
- Key bodies supportive of the role of aged care pharmacist.
- Some Aged Care providers are following Goodwin's lead.

Key responsibilities

GOODWIN
THE BETTER LIFE CHOICE

- Medication review and reconciliation.
- Supply pharmacy and GP liaison, including case conferences.
- Staff education, formal and informal.
- Provision of flu vaccines for facility staff.
- Contribution to governance committees.
- Increasing awareness of the unique role with key bodies such as PSA and LASA.

Proactive clinical team

Attending handover and clinical rounding promotes:

- Prioritisation of medication reviews,
- Prioritisation of resident related issues,
- Prioritisation of pharmacy related issues.

Supply pharmacy liaison

Ability to communicate Pharmacist to Pharmacist:

- Reduces the risk of misunderstandings / misinterpretations.
- Assists clinical staff to understand PBS and pharmacy regulations.
- Destroying of obsolete S8 medications promptly.

GP liaison

- Prioritisation of clinical issues.
- Involvement in family case conferences.
- Maintenance of medication charts in line with legislation.
- Ongoing review of the use of antibiotics, opioids, chemical restraints in line with current requirements.

Facility staff education

- Opinion given during daily attendance at handover and clinical rounding.
- Responsibility for the training of medication assistant training.
- Ad hoc and scheduled training sessions as required.

Staff flu vaccines

- Intensive daily clinics carried out for the first two weeks of May.
- Residential care staff vaccination levels at 90% at two sites, 75% at the third site.
- Influenza A outbreaks in early June and early September at one site.
- No serious illnesses were reported either by staff or residents following outbreaks.

Governance

- Responsibility for the running of the quarterly Medication Advisory Committee and Antimicrobial Stewardship Committee.
- Report to, and attend, Clinical Governance Committee which reports directly to the Goodwin Board.

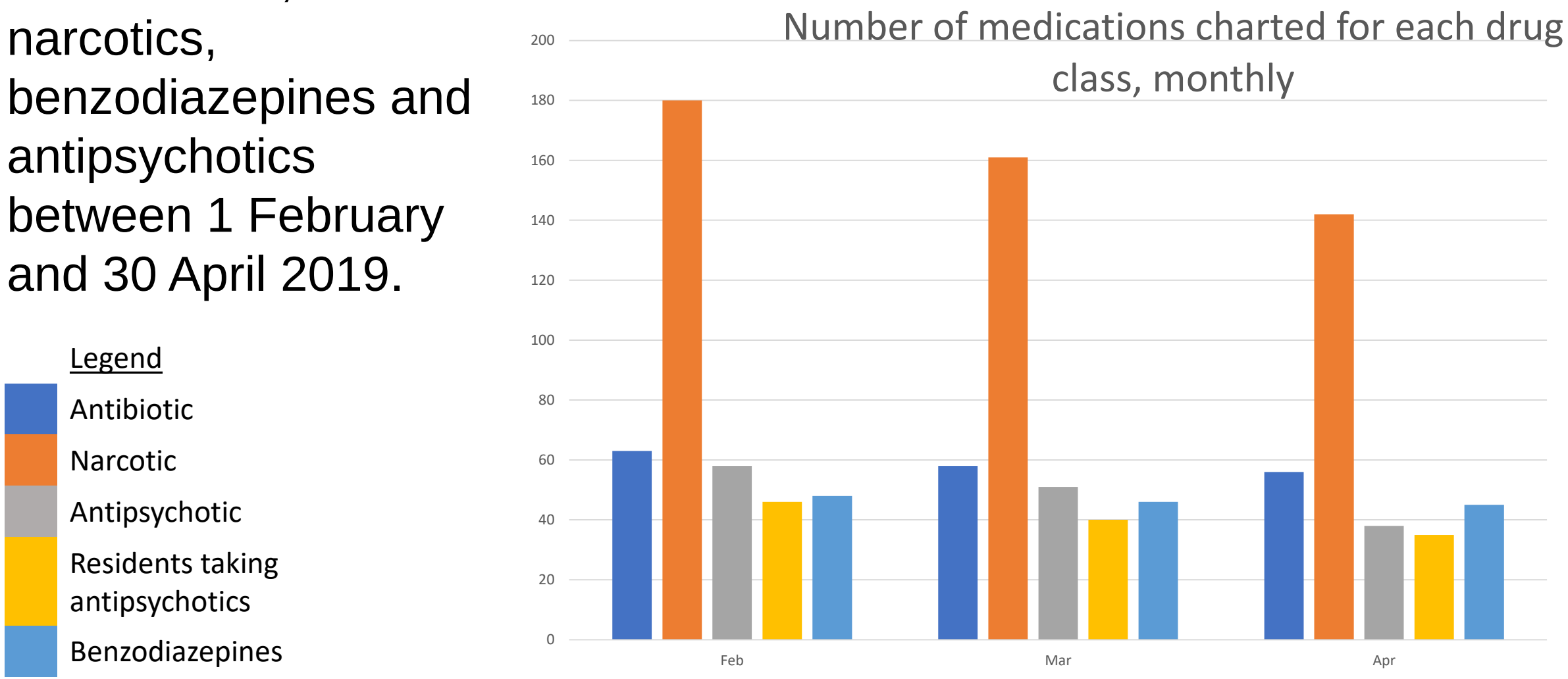
Antipsychotics, opioids and antibiotics

As at 17/5/19 residents at Goodwin had the following diagnoses:

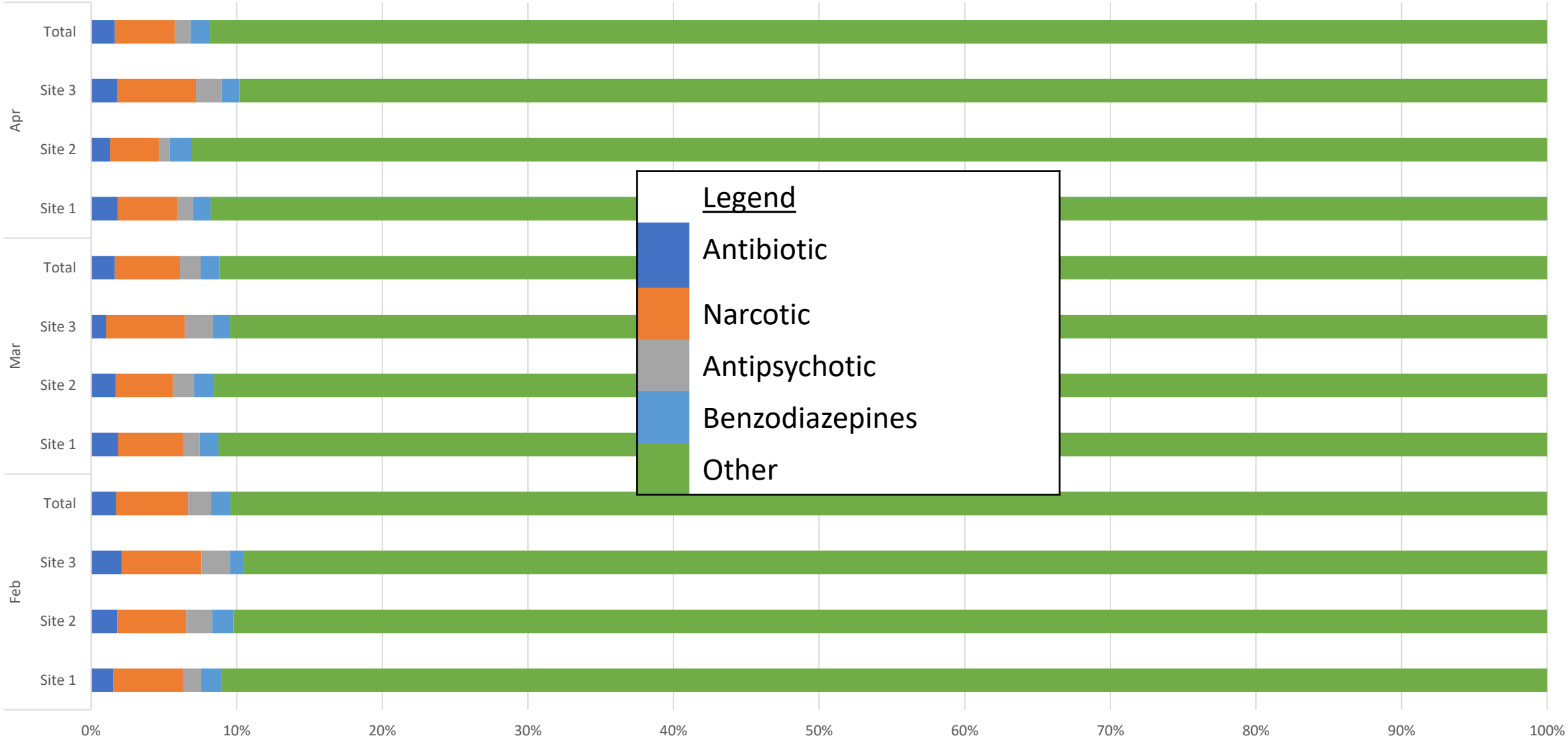
- 46% have a formal diagnosis of dementia, a further 7% have a diagnosis of cognitive decline.
- 9% have a diagnosis of anxiety.
- 6% have a diagnosis of schizophrenia or other related condition.

Trends in the charting of antibiotics, narcotics, benzodiazepines and antipsychotics between 1 February and 30 April 2019.

GOODWIN
THE BETTER LIFE CHOICE



Percentage drug class use per facility



Analysis shows between 1 February and 30 April that the:

- Average number of medication orders across all sites fell by 4%
- Average number of oral antibiotics across all sites fell by 12%
- Average number of S8s across all sites fell by 21%
- Average number of charted antipsychotics fell by 22.5%
- Average number of residents taking antipsychotics fell by 24%
- Average number of charted benzodiazepines fell by 6.25%

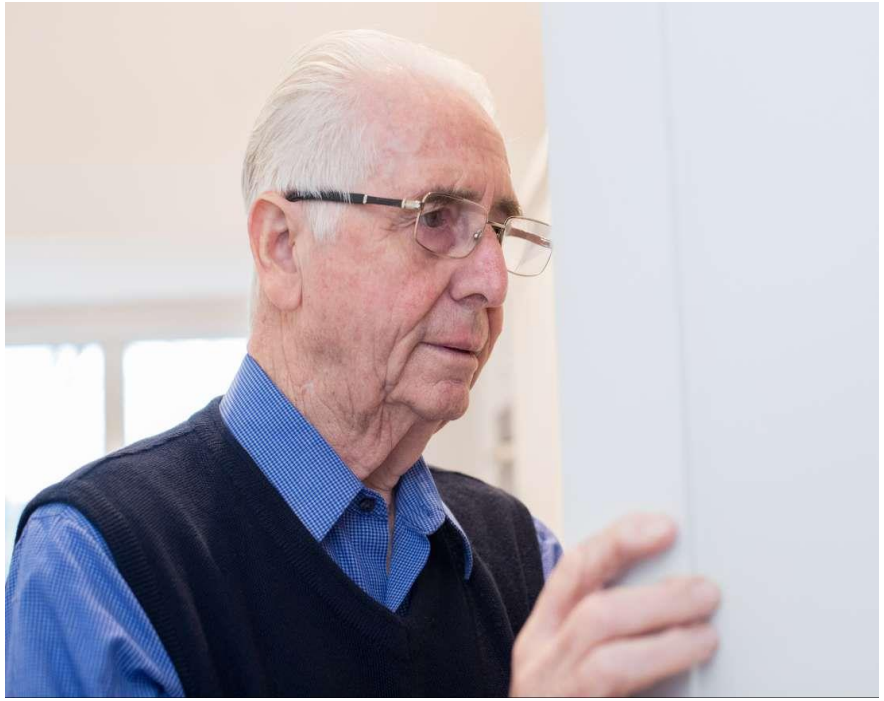
Analysis shows between 1 February and 30 April that the:

- Percentage of charted medications which are antipsychotics in April was 1.4%
- Percentage of charted medications which are benzodiazepines in April was 1.4%
- Percentage of charted medications which are S8 medications in April was 4.5%

Case study

RMMR for new admission:

Mr S.B. Aged 86, previously living alone at home. Four falls with hospital admissions in the three weeks since admission



Diagnoses – GORD, OP, HTN, LBD, necrosis of Lt hip and Rt Elbow, CVA (2016), AF, glaucoma.

GOODWIN
THE BETTER LIFE CHOICE

Medication regimen prior to review:

- Alendronate 70mg weekly
- Metoprolol 12.5mg nocte
- Omeprazole 20mg mane
- Paracetamol 1g tds
- Perindopril 4mg dinner
- Quetiapine 12.5mg mane 25mg nocte
- Simvastatin 5mg nocte
- Buprenorphine 15mcg Patch weekly
- Coloxyl with Senna 2 bd
- Probiotic Capsules 1 mane
- Prednisone 4mg mane
- Vitamin D3 1000u mane
- Rivaroxaban 15mg mane
- Xalacom Eye Drops nocte
- Movicol Sachets mane
- Diclofenac 1% gel bd to knees
- Rivastigmine 5 Patch daily

Issues discussed at resident / RN / carer interviews:

- No issues with behaviour management related to LBD.
- Started refusing doses as he feels he takes too many tablets.
- Struggles to swallow paracetamol tablets.
- Pain management has been effective.
- Falls have occurred in his bathroom when trying to self-toilet,
- Sent to hospital following falls as per protocols for residents taking NOACs

Mr S.B. timelines

- 0700 pharmacist made aware that resident requested advice re medications.
- 0730 – 0930 RMMR template populated and notes read. GP contacted to authorize RMMR.
- 1000 – 1030 Resident interviewed, his preferences / concerns were documented.
- 1030 – 1130 RMMR report finalized and sent to GP
- 1200 GP acknowledged receipt of report and confirmed he would visit the resident in the evening.
- 1700 Changes made to regimen by GP.

Changes made

- Simvastatin, quetiapine, vitamin D3, paracetamol, Coloxyl with Senna and alendronate ceased.
- Denosumab injections 6 monthly, Panadol Minicaps, prn quetiapine, weekly doses of D3 liquid started.
- Family case conference with GP, RN and Pharmacist scheduled for following week to discuss pain management (possible reduction in Norspan), risk / benefit of continuing rivastigmine and rivaroxaban, need for PRN quetiapine.

Case conference results

- Case conference held 10 days after initial changes were made. No further falls have occurred.
- PRN quetiapine ceased, not used, not necessary.
- Buprenorphine and rivastigmine patches ceased as resident had started removing them as they caused persistent itch.
- MS Contin started to manage persistent hip pain. Mr S.B. has taken the drug with good effect in the past.
- Further assessment for clinical need for rivastigmine in one month.

GOODWIN
THE BETTER LIFE CHOICE

Thank you

Richard Thorpe
Accredited Pharmacist