

Role of a Pharmacy Technician in an Intermediate Care setting

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What is Intermediate Care (IC)?

- It is a service designed to ***‘provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximize independent living’***

NSF for Older People, Standard 3:
Intermediate Care p.41

My role:

- This post was created after a pilot study revealed a number of medication errors within a designated Intermediate Care facility.
- The post is jointly funded by, the acute trust, the primary care trust (PCT) and social services.
- The aim of the post is to provide seamless medicines management across the different care settings.



How my time is spent....

- Approximately 50% of my time is spent at the acute trust.
- Main duties include:
 - POMMs (Patient orientated medicines management scheme) for a designated ward
 - Medication histories are carried out for any new referrals for IC
 - Authorised checking



How my time is spent.....

- The rest of my time is spent at the designated IC facilities (in this case two residential homes in Darlington)
- Checking medication administration record (MAR) sheets
- Promote self-administration of medication
- Medication reviews
- Document all errors and interventions made
- Education of clients and staff regarding medication



How my time is spent....

- Liaise with:
 - The client
 - GP surgeries
 - Community Pharmacies
 - District Nurses
 - Clients family and friends
 - Care home staff



How my time is spent....

- Weekly bed status meetings, to discuss clients progress
- Monthly multi-disciplinary team (MDT) meetings, to assess the service we provide.
 - MDT comprises of IC team leader, care manager, physiotherapist, occupational therapist and admin support.



How my time is spent....

- I have two line managers:
 - Lead clinical pharmacist at the acute trust.
 - We have monthly meetings to clinically review all clients
 - Deputy head of pharmacy and prescribing for the PCT
 - We have monthly meetings to review service provided

Example of an Intermediate Care referral

- Client referred to Intermediate Care Service (ICS) following a fractured right hip, and received hip operation at DMH.
- Visited client on Ward 14.
- Medicines prescribed on Kardex:
 - Atenolol 25mg od
 - Amlodipine 10mg od
 - Latanaprost eye drops 1 drop BE bd
 - Ferrous Sulphate 200mg tds
 - Lactulose 15ml bd
 - Perindopril 4mg od
 - Cosopt eye drops 1drop BE bd
 - Paracetamol 1g qds
 - Calfovit D3 1 sachet od
 - Codeine Linctus 5-10ml prn



Example continued...

- GP surgery contacted to confirm medicines pre admission.
 - Client also took Bendroflumethiazide 2.5mg daily.
 - Perindopril was recently started one month previously.
- Ferrous sulphate and Codeine linctus were new additions started in hospital.

A decorative graphic at the top of the slide consists of two groups of three circles. The first group on the left has a solid purple circle on the left, a white circle with a purple outline in the middle, and a solid purple circle on the right. The second group on the right has a solid purple circle on the left, a white circle with a purple outline in the middle, and a solid purple circle on the right.

Action taken

- Advised Latanaprost to be used **once a day** at night.
 - Doctor changed on Kardex.
- Investigated why Bendroflumethiazide not prescribed.
 - Due to client having a low sodium level.
- Ferrous sulphate started.
 - Due to low Hb following operation.



Actions taken continued...

- Investigated why prescribed codeine linctus: client complaining of cough.
 - Consulted Pharmacist- then I advised Doctors to review Perindopril as this was why client had developed cough.
 - Doctors reviewed medicines & stopped Perindopril & increased Atenolol to 50mg daily, & monitor BP. (If this not suitable Losartan to start)
- This action did delay hospital discharge by a couple of days, as client received closer BP monitoring due to dosage change of Atenolol.



Actions taken continued...

- Checked discharge prescription for any transcription errors.
- Client eventually discharged into ICS.
- Client informed of changes to medication and reasons why.
- Staff at care home advised to monitor BP, and cough.
- GP informed of medication changes, and reasons for changes.
- Also requested GP to monitor Hb level and review use of Ferrous Sulphate.



Example of intervention

- Client already at a designated IC facility
- Client re-admitted to hospital by GP with a suspected DVT
- Client was assessed at hospital, DVT confirmed, and sent back to IC on DVT pathway (Enoxaparin and Warfarin) A prescription was not written for rest of clients medication
- Client was taking Aspirin and Clopidogrel pre-admission to hospital



Action taken:

- Contacted admitting ward at hospital (no-one able to help)
- Contacted ward client had 'slept out' on (no-one able to help)
- Contacted Consultant, who passed me over to relevant SHO
- Result: Aspirin and Clopidogrel to STOP.
- MAR chart amended, client informed (as they were self medicating) care home staff informed, GP surgery informed.
- Incident report completed

Key developments



- Between November 2004 and October 2005:
- I have reviewed 126 clients medication.
- Documented 113 interventions of varying complexity, eight of which I completed Incident report forms for (acute trust) and three significant event forms (PCT).
- Try to implement self-administration of medication to appropriate clients. 35% of clients assessed have been successful.

Key developments



- I have achieved the AAH Clinical Technician of the year award 2005 for my project on 'Improving client care and reducing medication errors in an Intermediate Care setting' Which in turn has given me the opportunity to present my work at various forums, including the ASHP conference in Las Vegas, to help raise awareness of Intermediate Care services, and educate people about my role.