Embedding clinical pharmacists in critical care rehab carousel clinics

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Introduction

Clinical pharmacists specialising in critical care have become integrated into the critical care workforce providing valuable contributions to patient care[1,2,3]

Medicines reconciliation on admission to and discharge from critical care is included specifically within the commissioning standards[3]

On admission to critical care, clinical focus changes from management of chronic conditions to that of immediate preservation of life

Unprecedented pressures experienced during the COVID-19 pandemic have resulted in stretched staff to patient ratios and mobilisation of less experienced staff. This has negatively impacted the end to end reconciliation process causing patients to be discharged home with unresolved medicines discrepancies

In line with recent NICE[4] and Intensive Care Society guidance[5], rehabilitation of patients post-critical care is important in completing unresolved actions and optimising care. Consequently in September 2020 a carousel rehab clinic was introduced, running on two days per week

Objective

To embed a pharmacist within the rehabilitation clinic to focus on any unresolved medicines reconciliation issues

Methodology

Five senior critical care pharmacists (band 8a or above) participated in service provision to the clinic

For consistency and structure, a local SOP and electronic note template were produced

All interventions recommended were discussed with the patient at the time and for GPs to review and action as appropriate in the context of their responsibility for ongoing care and was fed back to GPs in a clinic summary letter

Data collection for this service evaluation was retrospective and performed by one of the critical care pharmacists who had participated in the clinic

Historic clinic dates for September – November 2020 (inclusive) were reviewed on the electronic scheduling system to identify patients who attended clinic; these were then filtered for pharmacist entries to ascertain:

- Number of patients reviewed
- Number of medication-related interventions made
- Intervention type and medication(s) involved

Results

- 51 patients were reviewed
- 59 medicine interventions made
- Mean interventions per patient was 1.2
- Range of 0 – 7

Eight intervention categories were identified (see figure 1)

Examples of significant interventions made include:

- Stopping acutely initiated bisoprolol (resolution of acute AF secondary to acute sepsis/volume depletion on ICU)
- Stopping of acutely started olanzapine for ICU-related agitation/delirium
- Dose optimisation of bisoprolol (post recent NSTEMI)
- Re-initiation of atorvastatin (for secondary prevention of IHD)

Conclusions

Medication interventions made by pharmacists in the post ICU rehabilitation clinic setting are clinically significant and add value to patient care both in terms of morbidity and mortality.

Our results demonstrate a reduction in polypharmacy burden in line with wider healthcare initiatives.

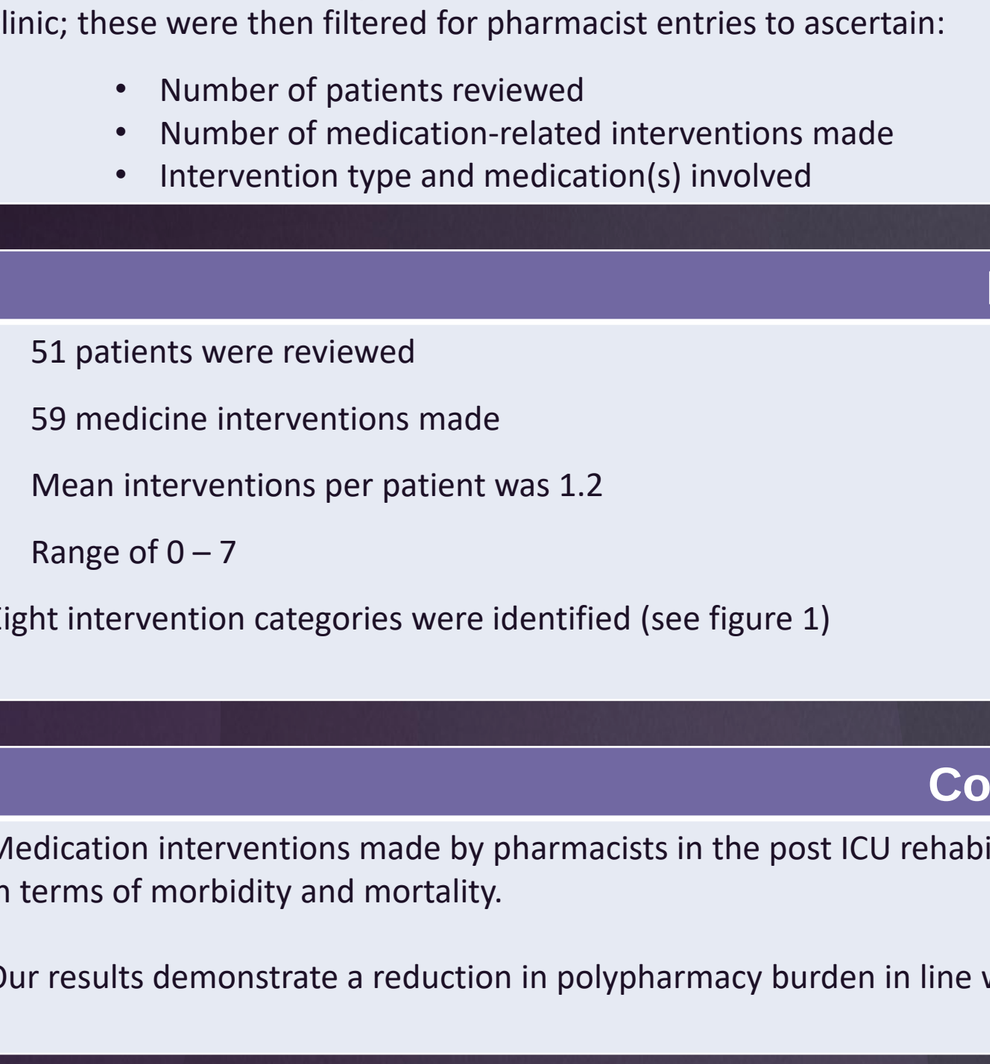

Figure 1: Pie chart depicting pharmacist clinic intervention type and percentage occurance

References

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