Welcome to the December 2017 newsletter; as ever feel free to pass it on within your networks.

Have you ever seen the film <u>Sliding Doors</u>? The central conceit being that, if at a particular juncture in life, you made an alternate choice to a decision you did make... how would that play out from the other option. The film shows both stories pan out with completely different consequences, based on whether the central character caught a train or not.

Doctor Who did it something similar in the episode <u>Turn Left</u>.

Anyway, this got me thinking about how things have changed in Pennine Lancashire since <u>Refer-to-Pharmacy</u> went live, especially in light of some of the vignettes that have been recorded by community pharmacists when they've been completing their referrals.

Once such instance recently was with an elderly lady, we'll call her Ethel, who had been admitted to hospital with what turned out to be a gastric bleed as a consequence of taking an oral anticoagulant (Rivaroxaban).

The anticoagulant was stopped as part of the hospital team 'fixing' Ethel, and the ward pharmacist made sure her discharge letter documented this important cessation.

Now, this is where the Sliding Doors part of this story happens...

In the real world the ward pharmacist referred Ethel to her community pharmacist so they were 'in the loop', and received a copy of Ethel's discharge letter.

In the alternate universe (or just over two years ago in Pennine Lancashire), *before* Refer-to-Pharmacy there was no communique sent to Ethel's community pharmacist.

Back in the real world, Ethel's GP received the discharge letter, and unintentionally did *not* change her prescription, *and* issued a fresh prescription for Rivaroxaban. The community pharmacist contacted Ethel's GP on receipt of this prescription *because* they had received a copy of her discharge letter via Refer-to-Pharmacy. The Rivaroxaban prescription was cancelled and Ethel came to no harm.

In our 'through the looking glass' reality, the GP's prescription was received by the community pharmacist who, oblivious to Ethel's hospital episode and the medicine changes, dispensed the prescription. Ethel restarted the oral anticoagulant, had another gastric bleed that brought her back to hospital with disastrous consequences.

Since March 2017, when new outcome measures were captured by the system, there have been *over 7000 referrals made* from East Lancashire Hospitals, and <u>122 have resulted in community pharmacists preventing unintentional</u> <u>prescribing errors on GPs' first post-discharge prescriptions</u>.

In other news, our transformational <u>Dedicated Ward Pharmacy</u> project is moving along nicely. An opinion piece has just been published in the Pharmaceutical Journal entitled <u>Tearing down walls to deliver a dedicated ward pharmacy service</u>.

All our new pharmacists and technicians have been recruited and the final few completed their induction at the beginning of December so we now have the service on twenty-four (of our thirty-three) wards so, amongst other things, the pharmacists are participating in daily ward rounds, and our technicians are writing the medicines sections of discharge letters.

Ward outcomes to November 2017 are looking promising, particularly our medicines reconciliation statistics. Take a look at these two run charts which show drug histories obtained by the pharmacy team; the first shows the percentage histories obtained, the second gives the absolute number.



The data comes from live data captured on our electronic patient tracking system and tells an interesting story.

And finally... as an early Christmas present to the ELHT pharmacy team, and to aid staff engagement, a small group of us have made a short humorous film. Inspired by Monty Python's 'Four Yorkshiremen' sketch (well, it's actually pre-Python and really from <u>At Last the 1948 show</u>... which was made in 1967).

So, we've brought it forward fifty years and given it a Dedicated Ward Pharmacy twist. We had great fun making it, and probably committed every filming, sound recording, and continuity blunder under the sun (we could have done with <u>elm media's</u> help!), and you can make your own mind up at:

http://bit.ly/DedicatedWardPharmacy_ItWerentLikeThatInMyDay_

Until next time.

Many thanks,

Alistair Gray | Clinical Services Lead Pharmacist | MRPharmS, BSc(Hons), DipClinPharm East Lancashire Hospitals NHS Trust | Pharmacy Department | Royal Blackburn Teaching Hospital |Haslingden Road | Blackburn | BB2 3HH

Telephone: Internal 82252/3 External 01254 732252/3 | Fax: 01254 734726 | e-mail: alistair.gray@elht.nhs.uk



Website: <u>www.elht.nhs.uk/refer</u> | Mobile App: <u>bit.ly/r2pharm</u> | Facebook: <u>ReferToPharmacy</u> | Twitter: @ReferToPharmacy