Does more specialist pharmacist time in a clinical area equal more activity?

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Background Following a medication safety initiative proposed by the PICU Safety Strategy group a pilot was set up to extend the presence of a PICU trained pharmacist in the clinical area.

One of the main safety initiatives was to assess whether increased pharmacist exposure decreased drug omission of time critical medicines, which was highlighted from incident reporting patterns on PICU.

Aim To assess what impact extending a pharmacist with specific PICU training would have on the medicines management of the PICU patients.

Method The pilot involved attendance on the afternoon ward round, review of all new admissions and follow up of priority patients as highlighted by the “day” PICU pharmacists. The pilot “late” PICU pharmacist was resident in the hospital, on PICU, for an hour longer than the pharmacy opening hours. A rota of

A basic data collection form was set up on Microsoft Excel. Data collected included start and finish times of the ward round, time leaving PICU, clinical interventions made, queries by staff on PICU and outside of PICU, supplies made, drug omissions prevented, number of times the presence on the unit prevented need to call in the on call pharmacist and interpretation of drug assays reported after pharmacy hours. Follow up of specific medicines management issues highlighted by the “day” pharmacists as requiring action prior to following day pharmacy visit were recorded.

Results During the 74 days data were collected there was 395 drug related queries by PICU staff (252 by nursing staff, 143 by prescribers). The “late” PICU pharmacist was contacted for advice regarding non-PICU patients by the on call or dispensary pharmacist on 7 occasions and 11 times from clinical staff outside of PICU.

The “late” pharmacist intervened on 412 prescriptions, some of the interventions arose from the 260 follow up reviews requested by the “day” pharmacists. Of the 236 drug assays reported after pharmacy hours, 126 required intervention by pharmacist.

Omission of time critical medicines was prevented on 17 occasions following 79 supplies of non-stock medicines. Calling out the on-call pharmacist was circumvented 11 times.

Conclusion The Safety Strategy teams’ request for increased access to a “late” PICU pharmacist resulted in a number of clinical interventions, appropriate dosing advice on late-in-day reported drugs assays and prevention of delays in medicines, including time critical drugs. Benefits of the specialist pharmacist being on-site to the pharmacy service included less need to access the on call pharmacist for either advice or supplies of medicines. During a pharmacy 7 day working review these data were used to secure the increased clinical pharmacy service to PICU.