

the post. As a crude marker of cost savings, we multiplied the average reduction in bed days (0.6 days) to the total annual activity (840) and priced an average bed day at £250. Ethics approval was not required.

Results

There were 840 cardiac surgical procedures between the months of January to December 2013, of which 286 were conducted by 2 consultants affiliated with the post. Average LOS across all consultants was 10.9 days. When data is adjusted and analysed for patients being discharged between days 4–14 (to eliminate outliers that skew data not due to this post), this reduced to 7.8 days. The average adjusted LOS for the 2 consultants affiliated with the post was 8.1 days in 2012 versus 7.5 days one year after the post was started (an average reduction of 0.6 bed days). In comparison, LOS reduced by 0.1 bed days in the same period in the control group. Additionally the post improved the proportion of elective patients discharged within 5 days compared to those under the care of the other cardiac surgeons, 23% vs 15% respectively. Reduction in LOS translates to a potential cost-avoidance of £126k, and potentially releases 504 bed days with potential to undertake an additional 67 cases per year (assuming an average LOS of 7.5 days).

Discussion

To determine whether this enhanced role or reducing LOS was adversely affecting patient safety, emergency readmission rates were analysed. There was no difference in readmission rates between study and control groups suggesting that decreasing the LOS in the study group did not adversely affect patient safety. The potential increased capacity could allow for fewer cancellations and ensure patients are being treated within 18 weeks from referral, preventing fines that may incur. The main limitation of this study was the use of retrospective data collected by the coding team, the accuracy of which being dependent on the quality of discharge summaries. With improvements in efficiency and financial benefits shown, we would advocate other trusts invest in discharge facilitators with pharmacists able to demonstrate improvements.

References

1. *The Society for Cardiothoracic Surgery in Great Britain & Ireland*. Blue Book Online. Available at <http://bluebook.scts.org/> [Accessed 23 February 2015]

0090

Optimising medicine administration in care homes: opportunities for pharmacists?

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Focal points

- This study aimed to identify difficulties experienced by nurses when administering medicines in care homes and strategies used to overcome them, using an ethnographic approach (observations).
- It was observed that nurses spent a significant proportion of their day undertaking medicine administration, and difficulties that led to time inefficiencies e.g. residents refused to consume all or some medicines were overcome with strategies such as administering medicines covertly in food or drink.
- The nature of observed medicine administration difficulties and strategies used to overcome them indicate that nurses could benefit from greater pharmaceutical input into medicine administration processes.

Introduction

Community pharmacists in the UK play a central role in the medicine management of older persons living in care homes (CHs). CH staff use pharmacy-prepared medicine organisers or pharmacy-dispensed original medicine packaging to administer large volumes of medicines to residents. However, there is limited published research that has ethnographically explored how medicine administration is conducted in CHs. Research of this nature could inform quality improvement of pharmacy-supplied medicine services. This study aimed to identify difficulties experienced by nurses when administering medicines in CHs and strategies used to overcome them.

Methods

This presentation reports on observations conducted as part of a larger, mixed methods study (conducted from October 2014 to March 2015). It involved a pharmacist researcher spending 3–4 days at five purposively sampled CHs in Greater London. The qualitative component involved observing nurses administer medicines during the breakfast, lunch and dinner medicine administration rounds (an ethnographic approach). The researcher aimed to observe 230 solid, oral medicine doses administered per CH (this determined the visit duration at each CH). University ethics committee approval was obtained.

Results

26 nurses were observed during 44 medicine administration rounds. It was observed that nurses spent a significant

proportion of their day undertaking medicine administration. Often, medicine administration did not occur time efficiently because residents required lengthy periods of time to consume medicines, or they refused to consume all or some medicines. Nurses employed various strategies to overcome these difficulties including: repeatedly re-visiting the resident to retry administration; crushing medicines; administering medicines covertly in food or drink; and asking a staff carer to administer the medicine. Observed consequences of time inefficient medicine administration included minimal time gaps between administration rounds and non-adherence to administration instructions of time- or food-sensitive medicines.

Discussion

The pharmacist researcher observed difficulties experienced by nurses when administering medicines, including lengthy periods of time for administration. Strategies nurses used to overcome these difficulties (e.g. crushing medicines and administration in food or drink) could benefit from an understanding of pharmaceutical principles. These findings will inform potential strategies to address observed medicine administration difficulties, for example: undertaking medicine reviews to identify opportunities for de-prescribing; using alternative formulations for prescribed medicines e.g. liquids, crushable forms or patches; regularly reviewing and communicating individual residents' medicine administration preferences; ensuring widespread awareness of medicines with important time, food and crushing sensitivities; and undertaking education on how to administer medicines with food or drink to ensure they are consumed in their entirety and their pharmacological effects are not impaired. Pharmacists have a role in improving care in CHs.¹ Future research could explore how pharmacists can support CH medicine administration processes, in terms of difficulties nurses experience and strategies to overcome them.

References

1. Royal Pharmaceutical Society. *Pharmacists improving care in care homes*. Great Britain: Royal Pharmaceutical Society, 2014.

0091

Reviewing the continued need for pharmacotherapy in the treatment of urinary incontinence

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Focal points

- Trial stop of medication to treat urinary incontinence to determine continued need for treatment
- Out of 70 of the patients asked to trial a stop in treatment ~73% remained stopped after an eight week period
- An estimated annual saving of £14,542 was achieved for the practice involved

Introduction

Urinary incontinence (UI) is a common symptom that can be caused by one or more underlying conditions. It has a wide range of severity and symptoms and patients can often find it very distressing, socially disruptive and embarrassing to discuss¹.

Antimuscarinics are frequently initiated in primary care to treat UI and patients often remain on these long term without regular review for continued need. National Institute for Health Care and Excellence Clinical Guidelines 171 (NICE CG171) recommend annual review in primary care (or every 6 months if over 75 years). They do not give any guidance as to how this should be done.

Methods

A search was carried out on the medical practices' clinical system using its reporting function to identify patients prescribed antimuscarinics to treat UI in the last year:

Each patient was individually reviewed using their clinical notes; the patient was not contacted as part of the review process.

Patients excluded during the review process include:

- Treatment less than 1yr (or less than 6 months if over 75yrs)
- Attending continence clinic or consultant input
- Parkinson's, Multiple Sclerosis or spinal cord injury
- Stroke, dementia, Alzheimer's – exclusion depended on severity of condition and if incontinence was associated.
- Life circumstance that deemed a change inappropriate

The remaining patients were sent a letter asking them to stop their medication. Their medication was removed from their repeat list to ensure the patient had to make contact with a prescriber/pharmacist before another prescription was issued. Ethics committee approval was not required.

Results

The search identified 210 patients in this practice currently using antimuscarinics. After the exclusions were applied 70 patients remained and were contacted to ask them to stop their medication.

Following a period of eight weeks 51 patients (almost 73%) had remained stopped, 2 had been switched to an alternative antimuscarinic as they had reported that they were still symptomatic on their original medication, 8 patients were unwilling to stop as they felt they still required these and 9 patients tried to stop but found their symptoms returned so were restarted. Patient satisfaction with this review was not analysed.

The cost of prescribing these medications on a daily basis for 12 months was worked out for each patient. These were then totalled and for the 51 patients that remained stopped this generated an estimated saving of £14,542 for the practice prescribing budget.

Discussion

This review confirms the need for regular review of antimuscarinics to treat UI. Almost 73% of patients asked to stop had remained stopped after an 8 week period which indicates that their symptoms may have resolved and that they no