PREVENT clinic (Pharmacist Review and EValuation of Existing and New Therapies)

Redcliffe Hospital

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Key Problem

- High readmission rates
- Large proportion of patients discharged from the internal medical service have chronic diseases and multiple co-morbidities
- Literature shows risk of medication misadventure highest at transitions of care (between hospital and community)
- Highest rate of readmission within 2 weeks of discharge.
- Inclusion of clinical pharmacist in ambulatory setting has documented benefits in the management of diseases such as diabetes, hypertension, smoking cessation and chronic kidney disease. PREVENT is an extension of this concept to include other patient groups such as neurology, rheumatology, respiratory and cardiac and thoracic medicine.

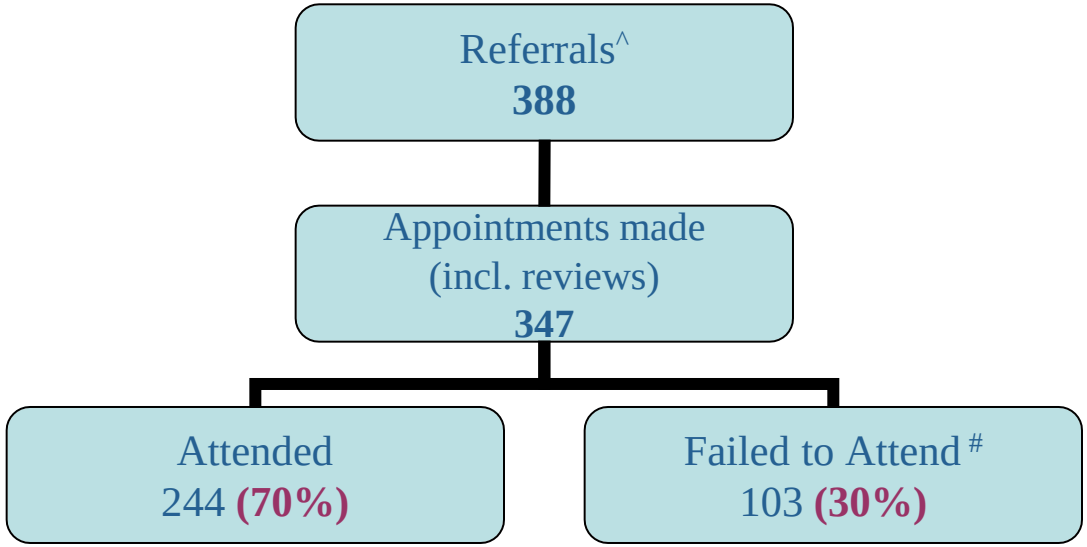
Aim of this innovation

- To determine if the PREVENT clinic (Pharmacist Review and Evaluation of Existing and New Therapies) can help in decreasing the 28 day hospital readmission rate of patients at high risk of medication related problems post discharge.
- Reduce hospital readmission of high risk patients by:
  - Medication review and reconciliation
  - Address poly-pharmacy
  - Prevent adverse drug events
  - Improve patient education and adherence to their medications
  - Improve clinical handover to general practitioner on discharge
- Review patients within 2 weeks post discharge .

Key Changes Implemented

- Developed local risk assessment tool to identify high risk patients.
- Referrals made to PREVENT clinic using referral tool by
  - Allied health
  - Medical staff
    - Ward based and specialist outpatient clinics
  - Nursing staff
  - Pharmacists (ED and ward)
- Appointment with clinical pharmacist offered within 15 days of referral by :
  - In-person outpatient appointment (linked with other appointments if possible).
  - Telehealth.
  - Phone review.
- Post PREVENT clinic appointment interventions escalated to general practitioner or referring team by phone or fax.
- A review appointment offered to patient (in person, Telehealth or phone review)

Outcomes so far



^Some declined appointment, unable to contact, discharged to nursing home, seen in other clinic (oncology/opioid stewardship).
Includes patients who cancelled a booked appointment, was an inpatient at time of appointment.

	Attended	Failed to Attend
28 Day-readmission	18 (5.2%)	37 (10.7%)
28 Day-mortality	1 (0.3%)	9 (2.6%)

Limitations: Patients who FTA may be those who are more complex, sicker and at higher risk.

Lessons Learnt

- Medication reconciliation and review post discharge help in :
  - Reducing readmission.
  - Detecting drug related problems.
  - Lowers rate of ADE.
  - Increase patient satisfaction.
    - Patients are generally unsure of what the service can provide for them, and after the appointment they feel empowered, heard and have a better understanding of their medications.
  - Opportunity for continuity of care:
    - follow up of patient progress after discharge.
    - Provides opportunity to liaise with general practitioner or referring team to address interventions in community setting.
  - Implementation of Telehealth
  - Barriers of new service implementation
    - FTAs
    - Uptake of new-service and maintaining referrals
    - No direct input from medical staff in medication management.
    - Do GPs really implement medication recommendations?

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