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## Standards and Guidelines

**Public Health England**

**Collection**
European Antibiotic Awareness Day: 2014 resources

First published: 4 October 2013 Last updated: 23 September 2014

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## New and Updated Cochrane Systematic Reviews

**Updated Reviews - November 2014**

Interventions for enhancing medication adherence

Over-the-counter (OTC) medications for acute cough in children and adults in community settings

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1. Title: (Future models of care) Educational intervention to increase hospital pharmacist exposure and instigate safe prescribing in undergraduate medical students: Our future doctors
Citation: International Journal of Pharmacy Practice, October 2014, vol./is. 22/(51-52), 0961-7671 (October 2014)
Author(s): Bassi H.
Language: English
Abstract: Introduction The National EQUIP study commissioned by the General Medical council in 2009 reported junior doctor prescribing error rate as 8.4%1 most importantly, they highlighted that these were 'potential' errors as picked up my ward pharmacists before they reached the patient: positively validating the imperative safety-net pharmacists provide. In light of the recent call for change in culture and improving collaborative relations between professionals within the NHS by making patients our highest priority2 this is an ideal opportunity for pharmacy to educate and promote models of synergistic and efficient inter-professional working via undergraduate education involvement. The aim of this study was to pilot an educational intervention of collaborating clinical pharmacists and 5th year medical student. The purpose of this intervention was to identify prescribing errors of current doctors, promote reflection with the aid of pharmacists on prescribing risk management and prevention and finally, an awareness and appreciation of the role, and support clinical pharmacists can provide. Methods The Hospital collaborated with the University Medical School to introduce a new hands-on educational intervention to improve prescribing awareness in 5th year medical students under the supervision of clinical pharmacists. The Hospital pharmacy department traditionally conduct an annual prescribing audit set against the in-house medicines policy across all 29 medical and surgical wards. Both medical students (87) and pharmacists (13) were recruited on a voluntary basis. In September 2013 all students were briefed on this educational intervention and given copies of both the medicines policy and audit form to familiarise themselves with. Each pharmacist was assigned six to seven medical students to take to their regular ward and select 2 patients/drug charts per student. Pharmacists were instructed to select drug-charts with a minimum of 5 drugs and hospital stay of >24 hours to ensure all students are exposed to a variety of prescribing. Students were directed to actively make the most of their appointed pharmacist to ask questions about prescription writing/drug selection etc. during the audit and in the scheduled Q&A session at the end. Data collection: via a questionnaire developed by a pharmacist, reviewed by a medic and piloted on three students. The final questionnaire, developed online consisted of four questions as follows: * Two closed questions with 5-point Likert scale (very rarevery common) exploring commonality of prescribing errors * Two open ended
questions delving into students understanding of why errors occur, and how they can be avoided. Data analysis: Closed questions data run on the online questionnaire service. Open ended questions exploring the reasons behind poor prescribing and preventative methods were analysed without any category coding methodology, but by a peer group of clinical pharmacists and medics who discussed the results and consensus delineated. Results * Eighty-seven medical students and 13 clinical pharmacists volunteered to take part. * Ninety-two per cent of students completed the survey before and 100% after the study. * Closed question: revealed 70% of students identified prescribing errors to be common/very common before the audit and 78% after the audit. 23%students stated it was common/very common for them to prioritise time for prescribing (in practice) and 56% after the audit * Open ended questions: A shift in student paradigm from 'excuse' (lack of knowledge/skills as the cause of prescribing errors thus more teaching/time/resources needed to remedy this) before the audit, to, autonomy (errors caused by rushing, guessing, human error, so remedy this by seeking help, using resources effectively, making prescribing a priority and giving it more time) Discussion After the intervention, medical students felt that prescribing errors were more common than they thought at the outset (8% increase) Following the Four Stages of Competence theory, data from our pilot suggest that junior doctors are 'conscience incompetent' rather than 'unconscious incompetent'. This illustrates an awareness of the challenges that exist for prescribing, and a need for pharmacists to support junior doctors with this task. Open ended questions allow us to explore this further. Reasons for poor prescribing before the intervention were linked with not completing necessary training and support due to lack of time and resources. However after the intervention we observe a shift in paradigm of the medical students: one of accepting responsibility by suggesting that prescribing errors can be avoided by prescribing clearly, taking time, asking for help, using resources i.e. BNF, Pharmacist! Prescribing under pressure and in isolation where the key contributory factors to prescribing errors in the EQUIP study.1 Junior doctors are under immense pressure when they first qualify: prescribing in isolation is dangerous and partnering up with a pharmacist, who are an under used resource4 is recommended. Increasing clinical pharmacist exposure to medical students at the ward level will help break these barriers. This shift from excuse to autonomy in seeking help is a key ingredient in efficient inter-professional relations. Through better working relations across professions: synergy and efficiency can be achieved. In this new age, adopting the NHS constitutional values5, working as a team we can put our patients are at the centre of our care. This small scale initiative to collaborate two departments and help each other has demonstrated small flickers of change in the hearts and minds of our future doctors, and hope will not feel isolated once qualified. The enthusiasm with which medical students approached this new method of teaching inspires to develop such initiatives further.

2.Title: An evaluation of the Royal Gwent Hospital pharmacy service at the weekend. Is the current service fit for purpose?
Citation: International Journal of Pharmacy Practice, October 2014, vol./is. 22/(85-86), 0961-7671 (October 2014)
Author(s): Lewis L., Hodson K.
Language: English
Abstract: Introduction Patients admitted to hospital at the weekend for emergency treatment are up to 16% more likely to die than those admitted during the week.1 The skeletonised weekend pharmacy service at the Royal Gwent Hospital (RGH), aimed at processing emergency items for wards. The department opens for 2-3 hours on a Saturday and Sunday; there are no ward visits. This unfunded service had grown such that costs were unmanageable and unsustainable. With current financial pressures and the Welsh Assembly Government striving for seven day working2, RGH pharmacy decided to undertake a service re-evaluation. The project aimed to assess the need for the current weekend service and to establish service users'; (SU) views on the minimum service needed to prevent patient harm and meet the needs of the Organisation. Methods Ethics approval was unnecessary as the hospital's Research and Development Office classed the project as service evaluation. Amixed method design was used. Quantitative methods recorded the work processed by pharmacy over six weekends throughout May/June 2013. Pharmacist interventions were collected and scored according to severity ratings as used in the EQUIP3 study. Cost avoidance was calculated using the Sheffield University cost effective model.4 The qualitative method comprised face-to-face semi-structured interviews. SU were purposively sampled from medicine, surgery, paediatrics and women's health and included doctors, nurses and managers. Forty SU were invited to participate via email. All interviews were recorded, transcribed verbatim and then thematically analysed (n = 27). Results Items processed by pharmacy over six weekends included stock requests (n = 125), controlled drugs (n = 56), in-patient medication (n = 439) and discharge prescriptions (n = 200). Over half of the dispensed discharges (n = 104) could have been processed on wards by nurses using the out of hours (OOH) Policy and pre-packs. Up to 50% (n = 95) of discharges were for patients who had not been admitted over the weekend. A total of 76 interventions were made in the
dispensary, calculated cost avoidance was <65,400. The interviews provided an insight into the perception of SU on the current service. Themes included: use of the service, identified limitations, service satisfaction and suggested improvements. It was perceived that ordering stock and medication at the weekend should be by exception. The general consensus was the fundamental function of the pharmacy at the weekend should be to improve patient safety. The majority believed that pharmacists on the ward at the weekend would be beneficial and reduce patient harm. Discussion The majority of SU were happy with the current service and thought it met their needs. Many valued the availability and accessibility of the service. Improvements are needed in ordering routine medication during the working week by the pharmacy team. Automated vending machines should be utilized for stock at the weekend. Ward based teams need to work together to improve discharge planning Monday to Friday. Use of the OOH Policy should be encouraged for discharges not requiring pharmacy input. Interventions demonstrated the important role played by pharmacy in minimising patient harm. It was encouraging to see how the role of pharmacy was considered pivotal for patient safety and in maintaining clinical governance by SU. To optimise use of the current service, SU need to be re-educated, allowing the weekend service to be utilised for emergency items only, releasing current staff to attend wards at the weekend. An increased clinical ward service provided by pharmacy at the weekend would improve patient safety.

Publication type: Journal: Conference Abstract
Source: EMBASE

3. Title: Are sufficient efforts being made by hospital pharmacy teams to encourage patients to access a Medicines Use review after discharge?
Citation: International Journal of Pharmacy Practice, October 2014, vol./is. 22/(8-9), 0961-7671 (October 2014)
Author(s): Corlett S., Goel P., Kothari S., Dodds L.
Language: English
Abstract: Introduction Medication errors can occur on transfer of care.1 dMURs were commissioned in 2011 to enable community pharmacists to support recently discharged patients by ensuring no unintentional changes in treatment had occurred, provide medicines information and encourage adherence.2 At the time, hospital pharmacy teams were encouraged to refer patients into this service. This study aimed to establish the provision of dMURs by community pharmacists and the practices of hospital pharmacy teams in referring patients into the service over an area covered by eight Clinical Commissioning Groups and served by four acute hospital trusts. Method Four hospital pharmacy trusts serving an area covered by eight CCGs were contacted by e-mail and asked to provide details of how they promote the dMUR service. All community pharmacies (n = 340) within the eight CCGs were asked by letter to participate in a short telephone interview. The structured telephone interviews lasted less than 10 minutes and explored participant uptake of, and perceived barriers to, dMURs using both open and closed questions. Data were analysed thematically and using SPSS version 21, respectively. University research ethics approval was obtained. Results Community pharmacists in 170 (50%) of pharmacies contacted took part in the survey. Of these, 53% (n = 90) had never conducted a dMUR despite 82% (n = 139) being the regular pharmacist. The main barrier to performing a dMUR was reported as not knowing a patient had been recently discharged. Participants were asked to estimate how many dMURs they performed each month (Table 1). HospitalsAand C reported they had prepared leaflets to promote the dMUR to patients. However, Hospital A reported they were rarely used and Hospital C that they had only been issued regularly for a few months after the initiation of the new service. Discussion Provision of dMURs remains extremely low in relation to the numbers of patients discharged. The findings are limited by the self-selection of community pharmacist respondents and the use of estimated rather than actual numbers of dMURs undertaken. Although hospital pharmacy promotional activity was absent in two Trusts and had virtually ceased in the other two Trusts, the higher estimated number of dMURs performed monthly in the catchment area of hospital C may reflect earlier promotional activity. This relationship between promotion and provision of dMURs is worthy of further study. (Table Presented).
Publication type: Journal: Conference Abstract
Source: EMBASE

4. Title: Collaborative pharmaceutical care in an Irish hospital: Uncontrolled before-after study
Citation: BMJ Quality and Safety, July 2014, vol./is. 23/7(574-583), 2044-5415 (July 2014)
Author(s): Grimes T.C., Deasy E., Allen A., O'Byrne J., Delaney T., Barragry J., Breslin N., Moloney E., Wall C.
Language: English
Abstract: Background: We investigated the benefits of the Collaborative Pharmaceutical Care in Tallaght Hospital (PACT) service versus standard ward-based clinical pharmacy in adult inpatients receiving acute medical care, particularly on prevalence of medication error and quality of prescribing. Methods: Uncontrolled before-after study, undertaken in consecutive adult medical inpatients admitted and discharged alive, using at least three medications.
Standard care involved clinical pharmacists being ward-based, contributing to medication history taking and prescription review, but not involved at discharge. The innovative PACT intervention involved clinical pharmacists being team-based, leading admission and discharge medication reconciliation and undertaking prescription review. Primary outcome measures were prevalence per patient of medication error and potentially severe error. Secondary measures included quality of prescribing using the Medication Appropriateness Index (MAI) in patients aged >65 years. Findings: Some 233 patients (112 PACT, 121 standard) were included. PACT decreased the prevalence of any medication error at discharge (adjusted OR 0.07 (95% CI 0.03 to 0.15)); number needed to treat (NNT) 3 (95% CI 2 to 3) and no PACT patient experienced a potentially severe error (NNT 20, 95% CI 10 to 142). In patients aged >65 years (n=108), PACT improved the MAI score from preadmission to discharge (Mann-Whitney U p<0.05; PACT median -1, IQR -3.75 to 0; standard care median +1, IQR -1 to +6). Conclusions: PACT, a collaborative model of pharmaceutical care involving medication reconciliation and review, delivered by clinical pharmacists and physicians, at admission, during inpatient care and at discharge was protective against potentially severe medication errors in acute medical patients and improved the quality of prescribing in older patients.

**Title:** Development of consensus guidance to facilitate service redesign around pharmacist prescribing in UK hospital practice.

**Citation:** International Journal of Clinical Pharmacy, October 2014, vol./is. 36/5(1069-76), 2210-7711 (2014 Oct)

**Author(s):** Tonna A, McCaig D, Diack L, West B, Stewart D

**Language:** English

**Abstract:** Background The last decade has seen a drive towards non-medical prescribing in the United Kingdom (UK). However, there is a dearth of any published literature on applying the principles of service redesign to support pharmacist prescribing in any sphere of practice. Objective To develop consensus guidance to facilitate service redesign around pharmacist prescribing. Setting UK hospital practice. Methods The Delphi technique was used to measure consensus of a panel of expert opinion holders in Scotland. Individuals with key strategic and operational roles in implementing initiatives of pharmacy practice and medicines management were recruited as experts. An electronic questionnaire consisting of 30 statements related to pharmacist prescribing service redesign was developed. These were presented as five-point Likert scales with illustrative quotes. Main outcome measures Consensus, defined as 70 % of panel members agreeing (ranked strongly agree/agree) with each statement. Results Responses were obtained from 35/40 (87.5 %) experts in round one and 29 (72.5 %) in round two. Consensus in round one was achieved for 27/30 of statements relating to aspects of generic ‘service development’ (e.g. succession planning, multidisciplinary working, quality evaluation, practice development and outcome measures) and
'pharmacist prescribing role development' (e.g. education and future orientation of service). Issues of disagreement were around targeting of pharmacist prescribing to clinical specialities and financial remuneration for prescribing in the hospital setting. Conclusion Consensus guidance has been developed to facilitate service redesign around hospital pharmacist prescribing.

**Publication type:** Journal Article  
**Source:** MEDLINE

7. **Title:** Economic evaluations of clinical pharmacist interventions on hospital inpatients: a systematic review of recent literature.  
**Citation:** International Journal of Clinical Pharmacy, December 2014, vol./is. 36/6(1101-14), 2210-7711 (2014 Dec)  
**Author(s):** Gallagher J, McCarthy S, Byrne S  
**Language:** English  
**Abstract:** Background Clinical and cost-effectiveness evidence are needed to justify the existence or extension of routine clinical pharmacy services in hospital settings. Previous reviews have indicated that clinical pharmacist interventions are likely to have a positive economic impact on hospital budgets but highlighted issues relating to the quality of studies. Aim of the review The primary aim of this review was to feature economic evaluations of clinical pharmacy services which targeted hospital inpatients. The review focused on the current cost-effectiveness status of different services, in addition to evaluating the quality of individual studies. Results of this systematic review were compared with cost-effectiveness and quality related findings of reviews which considered earlier time frames and alternative settings. Methods A systematic review of the literature included a review of the following databases: Academic Search Complete, Cochrane Library, EconLit, Embase Elsevier, NHS Economic Evaluation Database and PubMed. Only studies with an economic assessment of a clinical pharmacy service provided in a hospital setting were included. Data relating to the cost-effectiveness was extracted from eligible studies. Methodologies employed and overall quality of the studies was also reviewed. A grading system was applied to determine the quality of studies. Consolidated Health Economic Evaluation Reporting Standards statement was employed to determine which aspects of a high quality health economic study were employed. Results Twenty studies were deemed eligible for inclusion. Overall, pharmacist interventions had a positive impact on hospital budgets. Only three studies (15 %) were deemed to be "good-quality" studies. No 'novel'clinical pharmacist intervention was identified during the course of this review. Conclusions Clinical pharmacy interventions continue to provide cost savings. However, the standard of studies published has stagnated or even deteriorated in comparison with those included in previous reviews. Utilisation of published guidelines at initial stages of future studies may help improve the overall quality of studies.  
**Publication type:** Journal Article  
**Source:** MEDLINE

8. **Title:** Evaluation of hospital medication inventory policies  
**Citation:** Health Care Management Science, September 2014, vol./is. 17/3(215-229), 1386-9620 (September 2014)  
**Author(s):** Gebicki M., Mooney E., Chen S.-J., Mazur L.M.  
**Language:** English  
**Abstract:** As supply chain costs constitute a large portion of hospitals' operating expenses and with $27.7 billion spent by the US hospitals on drugs alone in 2009, improving medication inventory management provides a great opportunity to decrease the cost of healthcare. This study investigates different management approaches for a system consisting of one central storage location, the main pharmacy, and multiple dispensing machines located in each department. Each medication has a specific unit cost, availability from suppliers, criticality level, and expiration date. Event-driven simulation is used to evaluate the performance of several inventory policies based on the total cost and patient safety (service level) under various arrangements of the system defined by the number of drugs and departments, and drugs' criticality, availability, and expiration levels. Our results show that policies that incorporate drug characteristics in ordering decisions can address the tradeoff between patient safety and cost. Indeed, this study shows that such policies can result in higher patient safety and lower overall cost when compared to traditional approaches. Additional insights from this study allow for better understanding of the medication inventory system's dynamics and suggest several directions for future research in this topic. Findings of this study can be applied to help hospital pharmacies with managing their inventory. 2013 Springer Science+Business Media New York.  
**Publication type:** Journal: Article  
**Source:** EMBASE

9. **Title:** Evaluation of the discharge medicines review service in Wales: Community and hospital pharmacists' views
Communication was initiated between doctors and pharmacists for a variety of reasons. Results obtained. Interviews were conducted with 27 FY1 doctors. Three main themes were identified: (i) familiarisation, coding, pattern recognition, and (ii) verbatim and data analysed using a thematic approach. This approach to analysis involved the iterative stages of preferred communication methods between FY1 doctors and hospital pharmacists. Interviews were transcribed exploring recent examples of good and bad communication, disagreements in medication recommendations, and undergraduate pharmacy students (n = 2) conducted semi-structured interviews (seven CPs and six HPs). Both questionnaires ascertained: the pharmacist's engagement with the scheme, the discharge information provided and how it was communicated, barriers and facilitators to implementing DMRs and suggestions to overcome the barriers. In addition the CP questionnaire asked pharmacists views about the service and how it has impacted on patient care. The questionnaires were piloted (9 CPs and 10 HPs) and distributed electronically, in December 2013 to all CPs in Wales (n = 704) and in January 2014 to 369 HPs, using Survey Monkey. Reminders were issued via e-mail. Data were analysed in Microsoft Excel and Word. Results The CPs questionnaire obtained a response rate of 20% (n = 143). In the last month, 22% had undertaken two to three DMRs and 41% had not undertaken any. Overall, pharmacists' views about the service were positive, stating they contributed more to patient care (85%) and were 'doing something for the patient' (84%). Over half (51%) stated discrepancies identified were 'significant'. Specific barriers reported were: not knowing when the patient is discharged (78%), lack of access to discharge information (58%), lack of referral of patients (48%) and the nature of the DMR paperwork (44%). Over 80% of respondents called for discharge medicines information to be sent to the pharmacy or to enable access to electronic discharge information. The HPs questionnaire obtained a response rate of 25% (n = 94). Only 60% of respondents had ever referred a patient for a DMR. The main barriers identified were: other priorities within the hospital service (52%), lack of IT infrastructure (49%) and lack of promotion of the service to hospital pharmacists (42%) and patients (41%). Methods of communicating with CPs varied depending upon whether the patient required a compliance aid. In addition to rectifying the barriers identified, the main suggestion was for hospitals to receive feedback on their local DMR service (38%). Discussion Although the response rates for the two questionnaires were low, the results identified barriers to implementing the scheme and potential solutions. It also identified that some CPs and HPs are engaged with the process, while others are not. A number of ideas on how to improve engagement have been suggested and it will be interesting to see if implementing these will influence the breadth and depth of DMR provision across Wales.

**Abstract:**

Introduction The Wales DMR service was introduced in November 2011 to improve the management of medicines following the discharge of a patient from a care setting. The service was established in response to evidence which reports between 14 and 87% discrepancies in patients' medicines following discharge from hospital. The aim of the studies were to capture CPs and HPs' views about the DMR scheme. Methods Study approval was granted from six Health Boards' (HB) Research and Development Offices. Two questionnaires were developed; one for CPs and another for HPs. Content-setting for the questionnaires were informed by semi-structured interviews (seven CPs and six HPs). Both questionnaires ascertained: the pharmacist's engagement with the scheme, the discharge information provided and how it was communicated, barriers and facilitators to implementing DMRs and suggestions to overcome the barriers. In addition the CP questionnaire asked pharmacists views about the service and how it has impacted on patient care. The questionnaires were piloted (9 CPs and 10 HPs) and distributed electronically, in December 2013 to all CPs in Wales (n = 704) and in January 2014 to 369 HPs, using Survey Monkey. Reminders were issued via e-mail. Data were analysed in Microsoft Excel and Word. Results The CPs questionnaire obtained a response rate of 20% (n = 143). In the last month, 22% had undertaken two to three DMRs and 41% had not undertaken any. Overall, pharmacists' views about the service were positive, stating they contributed more to patient care (85%) and were 'doing something for the patient' (84%). Over half (51%) stated discrepancies identified were 'significant'. Specific barriers reported were: not knowing when the patient is discharged (78%), lack of access to discharge information (58%), lack of referral of patients (48%) and the nature of the DMR paperwork (44%). Over 80% of respondents called for discharge medicines information to be sent to the pharmacy or to enable access to electronic discharge information. The HPs questionnaire obtained a response rate of 25% (n = 94). Only 60% of respondents had ever referred a patient for a DMR. The main barriers identified were: other priorities within the hospital service (52%), lack of IT infrastructure (49%) and lack of promotion of the service to hospital pharmacists (42%) and patients (41%). Methods of communicating with CPs varied depending upon whether the patient required a compliance aid. In addition to rectifying the barriers identified, the main suggestion was for hospitals to receive feedback on their local DMR service (38%). Discussion Although the response rates for the two questionnaires were low, the results identified barriers to implementing the scheme and potential solutions. It also identified that some CPs and HPs are engaged with the process, while others are not. A number of ideas on how to improve engagement have been suggested and it will be interesting to see if implementing these will influence the breadth and depth of DMR provision across Wales.

**Citation:** International Journal of Pharmacy Practice, October 2014, vol./is. 22/(6), 0961-7671 (October 2014)

**Author(s):** Hodson K., James D., Smith M., Hughes L., Blenkinsopp A., Cohen D., Davies P., Turnbull L., O'Brien C., Alam F., Longley M.

**Language:** English

**Abstract:**

Introduction Communication problems between doctors and pharmacists are prevalent and known to contribute to medication errors. Identifying key features that facilitate or hinder communication could help inform strategies to reduce prescribing errors and improve pharmaceutical care. Pharmacists' drug chart recommendations are implemented 46-100% (median 79%) of the time but reasons for variation and non-implementation are currently unknown. Hospital pharmacists used a range of verbal and written communication methods and believed communication with doctors was important but challenging. However little is known about FY1 doctors' views of their communication with hospital pharmacists. The aim of this study was to explore FY1 doctors' views on communication with hospital pharmacists regarding their prescribing. Methods Letters of invitation and participant information leaflets were sent to FY1 doctors via contacts connected with three hospitals in England. All doctors who responded to the letter of invitation were contacted to take part. Trained pharmacist (n = 1) and final year undergraduate pharmacy students (n = 2) conducted semi-structured, audio-recorded interviews with FY1 doctors exploring recent examples of good and bad communication, disagreements in medication recommendations, and preferred communication methods between FY1 doctors and hospital pharmacists. Interviews were transcribed verbatim and data analysed using a thematic approach. This approach to analysis involved the iterative stages of familiarisation, coding, pattern recognition and theme development. University ethics committee approval was obtained. Results Interviews were conducted with 27 FY1 doctors. Three main themes were identified: (i) Communication was initiated between doctors and pharmacists for a variety of reasons and communication
frequency decreased as doctors became more experienced. FY1 doctors appreciated pharmacists' knowledge, skills and support. Many communication methods exist, but no preference was agreed upon. Pharmacists' recommendations were usually acted upon, and reasons for not implementing recommendations were generally discussed. (ii) FY1 doctors have a positive relationship with hospital pharmacists, but participants perceived senior doctors to have a less favourable relationship with pharmacists. (iii) FY1 doctors suggested standardising communication methods, working together on ward rounds, reviewing protocols, improving access to pharmacists, and increasing pharmacist-led teaching to improve communication. Discussion FY1 doctors and hospital pharmacists communicated frequently, however more needs to be done to engage senior doctors in communication and to ensure junior doctors retain positive relationships with pharmacists throughout their career. Findings from this study concur with previous studies that agreed improved communication was necessary to reduce prescribing errors. Suggestions to improve communication, e.g. greater pharmacist access, could be implemented to improve pharmaceutical care. Building a strong working relationship between all healthcare professionals should be encouraged to improve communication, collaborative working and pharmaceutical care, as confirmed by other studies that stressed the importance of knowing each other. Consistent communication methods may reduce miscommunication and potential medication errors, caused by the use of multiple communication methods. Implementing collaborative working strategies, e.g. joint ward rounds, would allow timely communication and efficient resolution of queries, which could improve pharmaceutical outcomes. The research team consisted mainly of pharmacists and pharmacy students, which may have influenced the analysis and interpretation of data.

**Publication type:** Journal: Conference Abstract

**Source:** EMBASE

**11. Title:** Falls prevention focused medication review by a pharmacist in an acute hospital: implications for future practice.

**Citation:** International Journal of Clinical Pharmacy, October 2014, vol./is. 36/5(969-75), 2210-7711 (2014 Oct)

**Author(s):** Browne C, Kingston C, Keane C

**Language:** English

**Abstract:** Background Patients at risk of falling are regularly prescribed medicines which increase falls risk. Medication review is a widely advocated risk reduction strategy. Objective The objectives of this descriptive study were to determine the number and types of falls risk medicines suitable for intervention, and to develop guidance to optimise the effectiveness of future medication related falls prevention initiatives. Setting An Irish acute teaching hospital and tertiary referral centre. Method 50 hospital in-patients at risk of falls underwent medication review focused on falls prevention by a pharmacist. Falls risk medicines were identified, and reviewed. If scope to discontinue, dose reduce or switch to a safer alternative was identified by the pharmacist, the suggested medication changes were communicated to the patient's care team. Main outcome measure Identification of the classes of falls risk medicines and types of prescriptions with greatest potential for intervention. Results The mean number of falls risk medicines prescribed to each patient was 4.8 (+2.8) and the total number prescribed to the 50 patients was 238. Following medication review, the pharmacist identified 48 (20 %) as suitable for intervention. Consequently, 34 medication changes (70.8 %) were implemented. Four medication classes accounted for over 80 % of medication changes. These were anti-emetics, opioid analgesics, anti-cholinergic agents acting on the bladder and benzodiazepines/hypnotics. Intervention was statistically significantly more likely to be possible in the case of p.r.n. medicines compared to regular medicines (p < 0.001, Chi square test). Medication reviews focused on falls prevention took an average of 23.5 min per patient to complete. Conclusion Medication reviews focused on falls prevention involve striking a balance between minimising medicines associated with falls and effectively treating medical conditions. We found only 20 % of falls risk medicines were suitable for change, and reviews were time consuming and resource intensive. However, targeting four medication classes, and being particularly alert to the potential to discontinue 'as required' medicines, has the potential to achieve most of the benefits of more comprehensive reviews. This information will guide the development of future falls risk medicine review initiatives in our hospital, increasing their feasibility in the acute hospital setting.

**Publication type:** Journal Article

**Source:** MEDLINE

**12. Title:** Hospital discharge summaries (HDS): Do they need pharmacist input?

**Citation:** International Journal of Pharmacy Practice, October 2014, vol./is. 22/(83-84), 0961-7671 (October 2014)

**Author(s):** Medlinskiene K.

**Language:** English

**Abstract:** Introduction The hospital discharge summary (HDS) is the main method of communicating patient's diagnostic findings, hospital management, and arrangements for post-discharge follow up to general practitioners.
HDS are additionally checked by hospital pharmacists if discharge medication supply is required. It is not unusual to receive complaints from patients about long waiting times for discharge medication. The study aimed to evaluate average time of a HDS journey and extent to which pharmacist input was required. Methods The data collection was performed during one week in November 2013 at one of three acute NHS Trust sites. All HDS received in the pharmacy had forms attached for time recordings (time a HDS was created, reached the pharmacy, turnaround time in the pharmacy). Data from HDS with completed time recordings was retrospectively analysed with Microsoft Excel to evaluate if pharmacist input was required. Any interventions, contributions and adjustments to HDS e.g. dose changes, additional instructions, completion of stopped medication box, completion of allergy status, were classed as pharmacist input. Ethical approval was not required. Results A total of 196 HDS had completed forms which represented 62% (314) of all HDS received that week by the pharmacy. The average time for one HDS to reach the pharmacy once it had been created was 1 h 4 min. Only 5% (10) HDS were in the pharmacy 24 h prior discharge as per trust policy.1 The average turnaround time for a HDS was 2 h 22 min, which was considerably lower on the weekend (1 h 18 min). Each HDS was collected or delivered to the ward on average within 33 min. The overall average time of HDS journey was 3 h 59 min. The majority of HDS, 75% (147), required pharmacist input. Pharmacist input was achieved by using information on inpatient drug cards, contacting ward (nurse or doctor), or both (Table 1). Discussion HDS are mostly written by junior doctors and errors are often associated with this junior status.1 Majority of pharmacist input was through obtaining information from inpatient drug cards and this reflects the poor quality of transcription performed by doctors creating HDS. Electronic system will possibly eliminate some or most transcription errors; however the Trust is likely to stay with the hard copy method for some time, we need to look into other approaches. Pharmacists could extend their transcribing from non-stock request sheets to the medication part of HDS. However, the issue stems from poor completion of medication part of HDS by prescribers. The next step is to see if extra training provided to prescribers on completion of medication part of HDS, can improve their transcribing skills and minimize the extent of pharmacist input required. Clinical check of HDS by pharmacists is not a standard procedure in the Trust1; only HDS requiring discharge medication are seen by pharmacists. This study highlights importance of clinical check of HDS by pharmacist as majority of HDS needed pharmacist input; potentially preventing medication errors. Future work will evaluate in more detail of pharmacist input required. Limitations of the study: a small sample, short timeframe and performance of the study only at one of three sites of the Trust. (Table Presented).

**Publication type:** Journal: Conference Abstract

**Source:** EMBASE

13. **Title:** Impact of hospital pharmacists on the paediatric discharge process

**Citation:** Archives of Disease in Childhood, August 2014, vol./is. 99/8(e3), 0003-9888 (August 2014)

**Author(s):** Barry M., Semple D.

**Language:** English

**Abstract:** Aim To evaluate the discharge planning process undertaken by hospital pharmacists in a paediatric hospital and to identify areas for improvement in the discharge planning process. Method Accurate and timely medicines information at the point of discharge is essential for continuity of care.1 Studies have been conducted on the role of the pharmacist in the adult discharge planning process but very few studies have been conducted in pediatrics.2 Many of the medicines used for infants and children are not licensed or available readily from community pharmacies. The dosage form of paediatric medicines is usually designed for adult use and may not be "age-appropriate" for a child.3 The pharmacy department contact community pharmacies daily regarding paediatric discharge prescriptions, providing information about the discharge medicines. A few days supply of medicines are commonly dispensed as unlicensed medicines and extemporaneous ingredients are not routinely stocked in community pharmacies. The authors contacted community pharmacies for each occasion a pharmacist was involved in the medication discharge planning process during January 2013. Pharmacists were invited to participate in a telephone survey regarding the discharge information they had received from the pharmacy department. They were asked to rate on a 5 point Likert scale the discharge information provided to them and medicine information provided to parents/carers. They were also asked if they had to order an unlicensed medicine or make an extemporaneous preparation or if the parents/carers received a patient medication chart. Surveys were entered into an Excel database and analysed. Results Forty-two community pharmacies were contacted and thirty-four pharmacists agreed to participate in the survey. The percentages of community pharmacies that were either very satisfied or satisfied with ordering details and timeliness of communication provided by the pharmacy department were 76% and 18% respectively. 82% of pharmacists were required to order an unlicensed medicine and 18% of pharmacists were requested to make an extemporaneous preparation. 44% of patients/carers received a patient medication chart. 89% of pharmacists were able to obtain a child’s medicines before the supply from OLCHC ran out. Conclusion The current discharge planning process is ensuring a high level of satisfaction amongst community
pharmacies with regards to timeliness and completeness of discharge medication information. Hospital pharmacists can provide accurate and timely information to community pharmacies regarding paediatric discharge prescriptions allowing seamless transfer of patients to the community. It was identified that all patient medication charts should be sent to the community pharmacy as standard practice.

**Publication type:** Journal: Conference Abstract  
**Source:** EMBASE  
**Full text:** Available ARCHIVES OF DISEASE IN CHILDHOOD at Archives of disease in childhood  
**Full text:** Available ARCHIVES OF DISEASE IN CHILDHOOD at Salisbury District Hospital Healthcare Library

14. **Title:** Improving the efficiency of a hospital pharmacy service: The journey of one hospital pharmacy  
**Citation:** European Journal of Hospital Pharmacy: Science and Practice, August 2014, vol./is. 21/4(208-215), 2047-9956;2047-9964 (August 2014)  
**Author(s):** Beard J., Ashley M., Chalkley D.  
**Language:** English  
**Abstract:** Objectives This article describes key changes made within one hospital pharmacy department in the UK during on-going work to improve services and meet the aims of the National Health Service (NHS) Quality, Innovation, Productivity and Prevention (QIPP) agenda. A series of projects designed to significantly increase the value of the service; reduce waste, increase efficiency and improve clinical services, without employing more staff, were undertaken. Methods The department used various change management techniques and lean methodologies to bring about change. This has been reinforced by robust and continual data collection and interpretation via run charts, to objectively demonstrate improvement. Results Average prescription turn-around times are approximately 25 minutes each day or less. Delays in provision of chemotherapy have fallen from around 60% to less than 5% of patients each day. Clinical pharmacists see approximately 98% of available inpatients each day and on average 92% of patients have their medicines reconciled within 24 h of admission. The Trust Medicines Management Improvement Group has also run a number of successful improvement projects to improve medicines safety. Conclusions The use of common change management techniques are applicable to hospital pharmacy and can result in measurable improvement in service delivery. It also indicates that the small size of a department is not necessarily a handicap to achieving better quality and efficiency in dispensary and chemotherapy production units, or in measurably addressing local and national patient safety concerns, without the need for additional staffing resources.  
**Publication type:** Journal: Article  
**Source:** EMBASE

15. **Title:** Information required by community pharmacists to complete a discharge medicine review for patients when they are discharged from hospital  
**Citation:** International Journal of Pharmacy Practice, October 2014, vol./is. 22/(7), 0961-7671 (October 2014)  
**Author(s):** Mantzourani E., Leggett H., Hodson K., Way C.  
**Language:** English  
**Abstract:** Introduction InWales a DMR1 service has been established where community pharmacists review a patient’s medicines on discharge, and see if there are any discrepancies between the medicines prescribed on discharge and the next prescription from the GP. There has been some debate about whether the patient’s Discharge Advice Letter (DAL) should be provided to community pharmacists. The NHS Wales Informatics Service (NWIS) were keen to identify whether all or some information on a DAL is required. The aim of this project was to identify the essential information pharmacists require to complete a DMR for a recently discharged patient. Methods A questionnaire was developed using the Royal Pharmaceutical Society (RPS) and Royal College of Physicians (RCP) guidance on the content of DALs, including information on demographics, diagnosis, allergies, medicines, and investigations. Open questions explored other information requirements and examples of where lack of information has put patients at risk. Following pilot for content and time taken to complete, a copy was sent to all 709 registered pharmacies inWales, along with a cover letter and a pre-paid envelope; the questionnaires were numbered to allow identification of non-respondents for follow-up. All results were transferred to Bristol Online Survey (BoS); descriptive analysis was implemented to see if there were any links between responses, and comments in open questions were thematically analysed. The project was granted approval by a university ethics committee. Results A 53.7% response rate was achieved, therefore no reminders were sent. Two hundred sixty-nine participants stated that they want to receive a copy of the DAL on discharge from hospital. Forty-five per cent wanted this in an electronic form and 41% by fax; 74.3% required this information within 48 hours of discharge, while 18% perceived that 48-72 hours is a reasonable amount of time. Patient and GP details, medication and medication changes, and person completing the record were deemed as essential information to be included in a DAL, whereas other contacts, diagnosis, allergies, medication recommendations, and information given to the patient and/or authorised
representative were considered desirable. Thematic analysis revealed patient eligibility and service awareness as key additional areas required. Patient risk was highlighted in medicine-related incidents mainly linked to lack of communication, lack of documentation of medication information, and patients who used multi-compartment compliance aids (MCA). Cross tabulation did not imply any relation between working environment or personal details and responses. Discussion This study achieved its aim of exploring information community pharmacists require in a DAL. A high response rate was achieved, therefore results can be generalised to the whole of Wales. Participants’ views reinforce the recommendations by RPS and RCP for the essential content of information in DALs, highlight the desire and need for access to the patient’s DAL, how that should be delivered and in what time frame. Results propose further information which is deemed essential to be included and communicated to community pharmacists, and identified patient groups (those using MCAs) that require increased notification of discharge and information to allow for improved patient safety and continuity of care. More significantly, this work presents examples of how lack of information and communication may lead to patient harm and can be used to support the case for allowing access for community pharmacists to patients’ health care records.

**Publication type:** Journal: Conference Abstract  
**Source:** EMBASE

16. Title: Investigation of the extent to which community pharmacists in two clinical commissioning groups feel able to support a hospital-initiated medication support referral service for older people  
**Citation:** International Journal of Pharmacy Practice, October 2014, vol./is. 22/(5), 0961-7671 (October 2014)  
**Author(s):** Ramsbottom H., Rutter P., Fitzpatrick R.  
**Language:** English  
**Abstract:** Introduction The Department of Health recommends that patients recently discharged from hospitals are routinely referred to community pharmacies to get the support they need to take their medicines effectively and that post discharge MURs should become an integral part of the medicine pathway.1 However, community pharmacists are rarely informed when one of their regular patients has been in hospital and pilot studies have shown that less than 3% of patients signposted to the service receive a post discharge MUR.2 Aim To assess the willingness and ability of community pharmacists to meet the needs of recently discharged older people with regards to the provision of MURs. Methods All community pharmacies (n = 77) in the area surrounding a district general hospital were sent information on the study along with a sign-up form. The form requested that the community pharmacist confirm their consent to partake in the post discharge MUR referral scheme being set up by the hospital, and provide their contact details, including a safe-haven fax number through which to receive referrals. They also had to complete a short tick box questionnaire to indicate whether they could provide domiciliary or telephone MURs. Forms were emailed to pharmacies via the Local Pharmaceutical Committee. These were circulated twice, after which pharmacies who had not returned sign-up forms were contacted by telephone to check they had received them and to answer any questions. Those who requested it were sent the details of the study again. Up to two further telephone reminders were made, to maximise recruitment. Ethics approval was gained from the local NHS Research Ethics Committee. Results Sign-up forms were received from 73 out of the 77 pharmacies in the hospital’s catchment area. Responses were totalled and the number of pharmacies able to offer domiciliary and telephone MURs is displayed in Table 1. A response of ‘possible’ was almost always (14 out of 15 responses) accompanied by a free-text statement, which when coded indicated uncertainty as to whether permission would be granted by the primary care organisation for the pharmacist to conduct the MUR either by telephone or as a domiciliary visit. Discussion This project has demonstrated an almost universal willingness (95% of those approached) of community pharmacists to be involved in a referral scheme from hospital to community pharmacy. However, only around half feel able to offer telephone MURs and less than one in five can offer domiciliary MURs. There also seems to be some degree of confusion around the procedure required to obtain permission to carry out telephone and domiciliary MURs. The fact that participants in the proposed study will be elderly and recovering from a period of acute illness may mean that they are unable or unwilling to make the journey to their community pharmacy for an MUR. This raises concerns over the practicalities of providing a post discharge MUR referral service in the current format to this patient group.

**Publication type:** Journal: Conference Abstract  
**Source:** EMBASE

17. Title: Learning to work with electronic patient records and prescription charts: experiences and perceptions of hospital pharmacists.  
**Citation:** Research In Social & Administrative Pharmacy, September 2014, vol./is. 10/S(741-55), 1551-7411;1934-8150 (2014 Sep-Oct)  
**Author(s):** Burgin A, O’Rourke R, Tully MP
Medicines optimisation in older patients: A qualitative study of the views of hospital pharmacists on the Medicines Use Review (MUR) and New Medicines Service (NMS)

Background: The use of electronic patient records (EPR) and electronic prescribing systems (such as electronic patient medication and administration records (EPMAR)) have many benefits. Changes and problems can result, however. Anecdotally, how pharmacists respond to system introduction varies greatly; there is very little information regarding pharmacists' experience in the literature.

Objectives: This study aimed to establish the changes that electronic systems afforded to hospital pharmacists' working practices and to investigate how and why they had responded to EPR and EPMAR.

Methods: Four semi-structured focus groups were conducted with pharmacists with different levels of seniority, with 4-6 participants in each. The focus groups were held 8 months after implementation of EPR and EPMAR were complete, and each focus group met once. Transcripts were analyzed manually using thematic analysis and data interpreted through the application of Actor Network Theory (ANT) and human activity systems as described in Engestrom's Expansive Learning Theory (ELT).

Results: The three main overarching themes identified involved reduced patient contact, professional representation in the clinical environment and documentation in the EPR. Pharmacists felt less visible to, and had poorer relationships with, patients as they no longer saw them when they checked prescriptions. Interprofessional relationships changed as pharmacists provided informal EPMAR training for doctors and spoke more often with nurses to relay important information. Changes in whether, what and how pharmacists recorded information also were seen, particularly between pharmacists of different generations and years of working at the hospital. Analysis of the changes afforded by electronic systems using ANT and ELT suggest that pharmacists develop individual working practices in response to changes that electronic systems provide.

Conclusion: For implementation success of EPR and EPMAR systems, pharmacists need to be taught not just the practicalities of system use, but also how to ensure that patients remain the focus of care, in response to the professional changes that may well occur following computerization.

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Publication type: Journal Article
Source: MEDLINE
Full text: Available Research in social & administrative pharmacy : RSAP at Research in Social and Administrative Pharmacy

18. Title: Medicines optimisation in older patients: A qualitative study of the views of hospital pharmacists on the Medicines Use Review (MUR) and New Medicines Service (NMS)

Citation: International Journal of Pharmacy Practice, October 2014, vol./is. 22/(62), 0961-7671 (October 2014)

Author(s): Umaru N., Aslanpour Z., Adegbesan A., Bhogal N., Hussain Z., Geeson C.

Language: English

Abstract: Introduction The Medicines Use Review (MUR) and New Medicines Service (NMS) were implemented as part of the advanced pharmaceutical care services provided to patients by community pharmacists. These services provided through consultations with pharmacists in most community pharmacies aim to facilitate patient adherence to medicine taking, improve patients' knowledge of their medicines, reduce medicines wastage and identify medicines related problems. A yearly remuneration quota for 400 MURs is set for each community pharmacy and of these, half should be undertaken for patients in any one of three target groups including patients who are: taking a high risk medicine, recently discharged from hospital and had changes made to their medication therapy whilst in hospital and patients prescribed specific respiratory medicines. In order to provide an informed service referral, hospital pharmacists should be knowledgeable about the provision of these services in the community.1,2 The extent of hospital pharmacists' knowledge and perceptions of these services have not been explored. The aim of this study was to explore the perceptions of, and practicability of initiating the MUR/NMS in the older patient population from hospital pharmacists' perspective. Method Patients to be discharged from the four elderly care and two medical wards at the Luton and Dunstable University Hospital are routinely signposted (provided with a patient information sheet) by hospital pharmacists and pharmacy technicians or referred by hospital pharmacists (completing a referral form) to undertake the MUR/NMS in the community post discharge. All pharmacist providing ward services to the elderly care and medical wards were approached to participate in this study. In-depth semi-structured interviews were undertaken with hospital pharmacists to seek their views on the practicability of patient signposting and referral. Conceptual content analysis was used to analyse interview data collated. Ethics approval was obtained from the NHS Newcastle and North Tyneside 2 REC. Informed consent for participation in interviews was sought and obtained. Results All (seven) hospital pharmacists working across the care of the elderly and medical wards took part in the interviews. All were female with post registration experience ranging from 1 to 30 years. Five main themes emerged from the interview data analysed including: (1) pharmacists' ambiguity about service specification, (2) lack of service awareness by patients, (3) barriers to patient engagement, (4) limitations to service provision and (5) suggestions for service improvement. From the emerging themes, hospital pharmacists introduced the MUR/NMS as time and judgement permitted often limited by other work commitments. Hospital pharmacists...
failed to identify opportunities for integrating medicines management between the hospital and community pharmacy sectors. A hospital environment was not considered to be conducive to introduce the MUR/NMS as patients admitted into hospital are often very ill and other priorities such as processing discharge medication took precedence to this service initiation. Limitations to initiating the MUR/NMS by hospital pharmacists included patients' disability and lack of independence. Other limitations reported included hospital pharmacists' lack of knowledge about MUR/NMS delivery and processes and limited prioritisation of initiating these services. Conclusions Hospital pharmacists would benefit from focused education on the MUR/NMS provided to patients in the community in order to knowledgeably promote signposting and referrals to these services. Policies to guide the referral and signposting of suitable patients should also be developed and implemented. Although engaging with older patients admitted to hospital can be challenging, this may prevent medicines related hospital admissions and readmissions. The small sample size in this study is a limitation impacting on data saturation. The views of more hospital pharmacists across different NHS Trusts should be sought to further inform this initial finding.

**Publication type:** Journal: Conference Abstract

**Source:** EMBASE

**19.** Title: Patients'; knowledge of their new medicines after discharge from hospital: What are the effects of nurse, doctor or pharmacist counselling and medicines use reviews (MURs)?

**Citation:** International Journal of Pharmacy Practice, October 2014, vol./is. 22/(100), 0961-7671 (October 2014)

**Author(s):** Elson R., Blenkinsopp A., Cook H., Kay J., Silcock J.

**Language:** English

**Abstract:** Introduction Helping patients to take medicines properly and safely is key to improving patient outcomes, improving quality and reducing waste in the NHS. Patients who are discharged from hospital often have new medicines prescribed and problems known to occur after discharge need to be addressed. Patient-centred advice has been shown to improve adherence to medicines. However little is known about the effects of current practice (nurse or doctor counselling) compared with targeted counselling from hospital pharmacists and MURs from community pharmacists. Methods A telephone survey was carried out by the lead researcher of 101 patients enrolled during May 2013 to September 2013, two weeks after their discharge from one NHS hospital with one or more new medicines. Patients were allocated sequentially to one of four groups; 1) Hospital pharmacist counselling, 2) Usual care (nurse or doctor counselling) + MUR, 3) Pharmacist counselling + MUR or 4) Usual care only. Patients who did not manage their own medication or those who were not able to provide consent were excluded from the study. The questions, which were piloted prior to the study, covered knowledge of: what the medicine was for, how to take it, side-effects, tests and monitoring. The Chi-squared test was used to compare the intervention groups with usual care. Likert-type scales were used to assess patients'; knowledge. Open questions were included to enquire about patients'; opinions on the service provided and the information they had received. A sample size calculation was not required as this was an exploratory study. Ethical and research governance approvals were obtained from the NHS. Results In total 84 of 101 patients recruited completed the study and were prescribed 154 new medicines. Age, gender and number of medicines were similar across the groups. Patients were able to recall the name of 130 (84.4%) 95% CI [76.6%, 92.2%] new medicines prescribed and could state what 127 (82.5%) 95% CI [74.4%, 90.6%] were for. For two-thirds of the medicines supplied to patients in group 4, patients reported that they were not provided with an explanation of how to take them compared to 6 (5.8%) in the intervention groups (p < 0.05). A greater proportion of patients in group 2 compared to group 1 were not provided with information on how long they will need to be on the medication (78.3% vs. 53.9%), tests or monitoring (69.6% vs. 36.8%) or what to do if they forget to take a dose (73.9% vs. 43.4%). There was no SOP for pharmacist counselling and is therefore not possible to determine whether areas were omitted due to time constraints or whether these are questions not usually covered. Eighteen patients had to be reallocated from groups 2 and 3 because they were unable to, or no longer wanted to have, a MUR but wanted to participate in the study. Discussion The results are limited to the amount of information the patient is able to recall however counselling patients in the intervention groups improved patients'; knowledge of their medicines compared with usual care. Possible strategies to address the study findings include providing telephone MURs to improve access, identifying patients'; MUR access and preferences while in hospital and targeting hospital pharmacist counselling more effectively, and providing feedback to the NHS about the need to develop the current discharge medicines information service.

**Publication type:** Journal: Conference Abstract

**Source:** EMBASE

**20.** Title: Pharmacist perception and use of UpToDate®.

**Citation:** Journal of the Medical Library Association, 01 October 2014, vol./is. 102/4(296-300), 15365050

**Author(s):** Wallace, Katie L., Beckett, Robert D., Sheehan, Amy Heck
Abstract: A cross-sectional survey of a convenience sample of 1,199 pharmacists was conducted to describe pharmacists’ use and perception of UpToDate®. Of 472 (39%) respondents, 217 (46%) reported using UpToDate. Most respondents who used or had heard of UpToDate indicated willingness to change a treatment plan based on UpToDate recommendations (77%). Many believed that UpToDate is updated weekly (31%) or monthly (49%) and that all articles undergo external peer review (51%). In conclusion, the majority of respondents reported that they would adjust drug therapy based on UpToDate recommendations; however, many pharmacists may hold misconceptions regarding the updating and peerreview processes.

Publication type: Journal article
Source: CINAHL
Full text: Available EBSCOhost at Journal of the Medical Library Association: JMLA

21. Title: Should community pharmacists receive electronic hospital discharge advice letters? The views of the public in Wales
Citation: International Journal of Pharmacy Practice, October 2014, vol./is. 22/(12), 0961-7671 (October 2014)
Author(s): Rowlands R., Hodson K., Hughes L., Way C., Warm D.
Language: English
Abstract: Introduction Hospital discharge summaries are vital in ensuring continuity of patient care across primary and secondary care settings and must provide reliable, complete information which is received within a reasonable timeframe. The NHS Wales Informatics Service has developed a new Medicines Transcribing and e-discharge (MTeD) system to transfer DALs to General Practitioners faster, more efficiently and more consistently. It has been proposed that DALs could also be sent electronically to community pharmacists for the purpose of conducting a Discharge Medicines Review (DMR). The aim of this study was to ascertain the views of the public across Wales on community pharmacists receiving DALs electronically. Methods Ethical approval was sought and granted for the study. Established groups across five Health Boards in Wales were invited to attend a focus group. These included people likely to be community pharmacy users and those who were not. Patients who had completed the DMR process in the previous 6 months were also invited, via their community pharmacist, to attend focus groups in the remaining two Health Boards. All focus group discussions were transcribed verbatim and analysed thematically. Results Focus groups of four to eight participants were held across three Health Boards with five established groups: an older person’s forum, a Community Health Council (CHC), a chronic condition support group, a parent and toddler group and a young persons’ social group. Twenty-eight participants with a range of ages, level of qualification and employment status were included. Six main themes and twenty nine subthemes were identified. Participants across all groups appreciated the benefits of pharmacists having access to DALs, including alerting them to hospital admissions, enabling more thorough medication checks and reviews, increasing the safety of prescribing and saving time and money. There were varying opinions on the content of the DAL that should be sent to community pharmacists due to the inclusion of potentially sensitive information: ‘I’d like them to have a picture of what I’m in hospital with, enough to make sure that the medication that is prescribed is safe and is appropriate for me and not much more I don’t think’. All were supportive of medication information being included; younger participants also supported the inclusion of further information including reason for admission and past medical history. All groups outlined advantages of using an electronic system, including; legibility, efficiency and cost reduction. The security and confidentiality of information, both electronically and within the pharmacy, were however of concern, particularly in the community pharmacy user groups. Participants, predominantly in the CHC group, were keen to ensure a rigorous consent process be established before the transfer of any information. Discussion These results show that the majority of study participants were broadly supportive of the transmission of discharge information electronically to community pharmacists. There were, however, several concerns expressed which need addressing. These primarily relate to confidentiality issues and include what specific information needs to be shared (in particular the need for sensitive clinical information), the security of electronic transfer and the security and confidentiality of the information once received by the community pharmacy. Further work to gain the views of the wider population in Wales is planned.
Publication type: Journal: Conference Abstract
Source: EMBASE

22. Title: The impact of counselling cardiology patients by pharmacists prior to discharge from hospital regarding their use of medicines
Citation: International Journal of Pharmacy Practice, October 2014, vol./is. 22/(64), 0961-7671 (October 2014)
Abstract: Introduction The Royal Pharmaceutical Society (RPS) released guidance 'Keeping patients safe when they transfer between care providers - getting the medicines right', which aimed to bridge the gap between different care sectors. Hospital admissions often lead to several changes to patients' medication, which can cause confusion, as well as discrepancies in prescribing in primary care. The aim of this project was to evaluate the impact of counselling of cardiology patients by a pharmacist prior to discharge through their satisfaction as well as knowledge about their medicines. Methods Ethical approval was not required as this project was considered as service evaluation. To obtain accurate results, a 'before and after' study was designed, where a control period was initially completed where patients were counselled by nurses as per current practice, followed by the intervention period where patients were counselled by a pharmacist prior to discharge. One pharmacist was responsible for counselling the patients in the intervention group. A questionnaire was used to obtain results. The first part of the questionnaire includes the validated Satisfaction with Information about Medicines Scale (SIMS) with the use of five-point Likert scale. Examples of the questions include 'what is your medicine(s) called?', and 'what is your medicine(s) for?' The second part had questions to determine patients' knowledge and their views about the service. Results Atotal of 94 patients were recruited; 48 patients in the control period, and 46 patients in the intervention group. The table below shows the satisfaction score for the information provided to patients about their medication. Mann-Whitney (U) test was used to determine whether there was any significant difference in opinion regarding the information provided in the two groups. There was a statistically significant difference between the responses of both groups (p < 0.05) for all the questions, indicating a significant increase in patients' knowledge about their medicines the intervention group. Discussion Pharmacists can have a significant input into the discharge process through improving patients' knowledge about medication. Better understanding about medicines will help improve adherence too. However, with the available resources it is not possible to provide patient counselling to all patients being discharged from hospital; therefore, prioritising patients who are at high risk to be counselled by the pharmacy team is important. It is also vital to ensure that nurses receive the appropriate training to provide an equal and acceptable amount of information about medication to all patients prior to discharge. (Table Presented).
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