A change in the consultant service at the Royal London Children’s Hospital has been supported by the pharmacy team and has provided opportunities for pharmacists to be involved in post-take ward rounds

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Imagine a typical weekday morning in a busy children’s hospital. After a night of admissions, consultants are assigned any number of acute patients in addition to their existing specialist caseload. All of the specialist consultants carry out a ward round, visiting each of their patients in turn, across the different areas of the hospital. There is often no set time, routine or pattern to these rounds and on a general medical ward there can be up to five different teams conducting rounds at the same time. At these times, factors such as a lack of space, limited nursing capacity and increased noise can lead to reduced quality of patient care.

It was this kind of scenario that prompted the general medical consultant paediatricians at The Royal London Children's Hospital (RLCH), Barts and The London NHS Trust, to try a new approach. In 2009 they changed to having a “consultant of the week” to deal with acute medical admissions. For any given week, one consultant team covers all patients admitted acutely to the hospital, instead of a different team each day. This team would conduct a post-take ward round (PTWR) each morning to review those patients admitted overnight. PTWR is an expression commonly used to describe ward rounds that take place to review newly admitted acute patients.

This change also brought the service at RLCH in line with the adult service at the The Royal London Hospital and “guidance on the role of the consultant paediatrician in providing acute care in the hospital” set out by the Royal College of Paediatric and Child Health.1

Pharmacy involvement

The change in consultant service was supported by the pharmacy team and was seen as an opportunity for pharmacists to be involved in PTWRs.

Presence on PTWRs means that pharmacists can contribute to multidisciplinary management of patients and intervene at the point of prescribing, if necessary.

Currently only senior paediatric pharmacists (band 8a) or specialist pharmacists (permanent band 7) participate in PTWRs to ensure adequate knowledge is on hand. Rotational pharmacists (band 6 and 7) are given the opportunity to participate when they are deemed to be competent and have had sufficient general medicine experience.

Advantages

The presence of a pharmacist on PTWRs in the US has been shown to reduce medication errors and prescription costs.2 In the UK research in large teaching hospitals has demonstrated that it benefits patient care, especially in the detection of errors.3

Participation in PTWRs promotes the role of pharmacists as valuable members of the multidisciplinary team. It also means that the pharmacist is aware of patients’ care plans and predicted discharge dates, all of which help to facilitate prompt medicines supply at the point of discharge. Under the traditional system, poor documentation of care plans and medicines management, combined with the fact that pharmacists were not present on many ward rounds, meant that the pharmacy department was often not aware that patients were being discharged from hospital until being told by the nurses some time after the ward round.

When pharmacists are present at the point of prescribing, newly started medicines can be ordered promptly and discrepancies between patients’ medication histories and drug charts can be promptly brought to the attention of the medical team and rectified.

The PTWR pharmacist can also positively influence prescribing, for example by:

- Giving practical advice on formulation issues
- Advising doctors on drug choice, dosing and formulary issues
- Rationalising medicines use
- Highlighting potential drug interactions and other medication-related problems
The presence of a pharmacist on the post-take ward round (PTWR) means that pharmacist interventions can occur at the time of prescribing. Some examples of interventions that have occurred on PTWRs are:

- Correction of rectal paracetamol dose
- Correction of gentamicin dose
- Ampicillin switched to amoxicillin for a 12-day-old baby with suspected meningitis or sepsis
- Correction of oseltamivir dose
- Advice on doses of domperidone and Gaviscon when baby started on treatment for reflux
- Fluticasone/salmeterol inhaler and fluticasone nasal spray not prescribed for a patient admitted for an asthma exacerbation

The PTWR case load can also be unpredictable. Sometimes the ward round is divided between two teams so that patients can be seen more swiftly (which is not ideal for pharmaceutical input since the PTWR pharmacist cannot be in two places at once).

There are often times when the ward round is interesting for the pharmacist, although not highly relevant (eg, intensive diagnostic examinations or in-depth discussions about social issues). It is, therefore, necessary for the PTWR pharmacist to be able to juggle other jobs, such as carrying out drug histories for the next patient to save time and preempt queries that may arise later in the round.

Currently the PTWR pharmacy commitments are shared between three pharmacists (each pharmacist covers the round every third week). Reallocation of these senior pharmacists to the PTWR for up to four hours each day ultimately means that time is spent away from their specialist areas where they can input into patient care. However, the PTWR also provides a medium for clinical learning.

A multidisciplinary approach to PTWRs also increases the size of the team and this can make some patients feel uncomfortable.

Ideally, the PTWR pharmacist undertakes medication histories for the patients due to be seen on the PTWR before the round starts. If this is not possible, it can be done after the PTWR, although this is less preferable since issues discovered while taking a drug history can be rectified during the round.

The PTWR team, including the pharmacist, changes each week so learning opportunities that arise from long-term follow-up of a patient do not occur. Additionally, there is a belief that complex or long-term patients may lose out since there is reduced continuity of care. However, with thorough handover this issue can be overcome.

The position of the PTWR pharmacist is not funded. Although every effort is made to staff the PTWR, if there is unplanned absence a pharmacist may not be available to take part.

The future
With the “consultant of the week” model and the presence of pharmacists on PTWRs, clinical screening and dispensing of discharge prescriptions are no longer the most common limiting steps in the discharge process. Future work to develop the service further may involve increasing the use of TTA pre-pack dispensing on the wards for commonly prescribed items on discharge (such as analgesics, antibiotics and inhalers).

We are also considering the feasibility of the PTWR pharmacist transcribing the drug section of the discharge prescription and the doctor double-checking what has been written. This may speed up the process because, in practice, pharmacists tend to have a great deal of input into what is prescribed.

References