COMMUNITY PHARMACY LONG TERM CONDITIONS SERVICE Case Studies

HOW CAN THESE STORIES HELP ME?

Each provides you with examples of:

- *How the Community Pharmacy LTC Service can help improve a patients medicines adherence and overall health*
- *How the role of pharmacists within multi-disciplinary teams are integral to the services' success.*

Joan's story

Joan is a middle aged woman who has suffered from several brain abscesses and consequently has significant memory issues.

She also has had 2 CVAs, has CHD and had a history of sporadic medication collection. She was registered in the Community Pharmacy LTC Service when her community pharmacist had difficulties reconciling her hospital discharge prescription against her pharmacy dispensing history.

This process highlighted significant barriers to Joan's medication adherence.

What actions were taken?

Joan's community pharmacist called in the help of her GP and referred to her shared care record before managing to reconcile her medicines. Together they discussed her medicines collection patterns and adherence before adjusting her medicines to reduce the polypharmacy.

They noticed blister packs were helping Joan but often she didn't collect them on time despite reminders.

New information from conversations shared

After a long phone call with Joan her pharmacists realised she couldn't afford the combination of the doctor visit fee and the cost of filling her prescription. If unable to collect her medicines there was no way she could remain adherent.

Often Joan went without medication for long periods, subsequently became unwell and was hospitalised. She had even accessed hospital A&E services in order to obtain what she considered her most important medications but only had them dispensed as she could afford them.

None of the health professionals in contact with her had previously known the full extent of her compliance issues or were aware of her significant barriers to health management.

Initiatives developed for Joan's LTC Medicines Management Plan

To resolve Joan's issues her multi disciplinary team developed a detailed medicines management plan which included:

- Financial support from WINZ, with automatic payments to the pharmacy for medication with the help of an Outreach Nurse.
- Joan's GP enrolled her in Care Plus so she was eligible for 4 free GP visits each year. She now has access to regular medical care and prescriptions.
- An Outreach nurse was appointed for home visits to check on her health. This was important as Joan's pharmacist had concerns for the patient's safety regarding overuse of another medicine (loose Zopiclone). Following discussions with the GP and the Outreach nurse the pharmacist initiated weekly blister packaging which included the Zopiclone.
- Her community pharmacy set up a diarised reminder to ensure Joan was reminded when her next supply of medicines was ready. Her Outreach nurse began bringing her into the pharmacy each week to collect it.

How has the LTC Service helped Joan?

Joan hasn't been admitted to hospital for over a year and has improved overall health which allows her to look after her grandchildren and participate in community activities again.

Joan now comes into the pharmacy each week on her own to collect her blister packs.

ANTHONY'S STORY

Anthony was a patient with HIV and diabetes who managed to stabilise his T-Cell count. His doctor got in touch with Anthony's community pharmacy because they realised he was eligible for the LTC Service and would benefit from the extra support the pharmacy could give him to keep him taking his medicines as prescribed in order to maintain his T cell count. Because of his diabetes Anthony was also on other medications which when combined with the side effects of his HIV meant he had associated liver problems.

What actions were taken?

Once registered in the LTC Service, the pharmacist synchronised Anthony's medicines and he began getting his other prescriptions faxed directly to that pharmacy.

Initiatives developed for Anthony's LTC Medicines Management Plan

- Diary reminders were set up in an online calendar shared by the community pharmacy team to ensure Anthony was contacted by phone well before he ran out of medicine.
- The pharmacist had a list of questions which they used to make sure these conversations were going to help him remain adherent E.g. When is your next scheduled blood test?
- Each conversation was noted in the community pharmacy's Pharmacy Management System
- Regular prescription collect enabled the pharmacists to:
    - find out more about his medicines usage
    - provide guidance and tips on how he should be taking the medicines.

How has the LTC Service helped Anthony?

Since registering for the LTC Service Anthony has maintained a stable T- Cell count and his pharmacists hasn't had to dispense antibiotics to him to treat infections. The feedback from Anthony's doctor and specialist has been positive and acknowledged how the pharmacist had been a key adherence tool within the multi disciplinary team keeping Anthony healthy.

EILEEN'S STORY

Eileen is 50 years old, has a history of heart disease and is getting some mental health support from her multi disciplinary team in the community. She is registered in the Community Pharmacy Long Term Conditions (LTC) service, has a medicines management plan which ensures she receives reminders from her pharmacist to collect her medications and is given her medications in blister packs.

What actions were taken?

Eileen was registered in the LTC Service. A key way the pharmacist provided Eileen with extra support was through the reconciling, synchronising and providing her with a list of her medicines. A medicines management plan was created for Eileen which included reminders to collect her medications each month. At each visit her pharmacist makes notes and draws arrows on her blister packs to help her remember how they should be taken.

How has the LTC Service helped Eileen?

She has told her pharmacy that the extra support helps her understand the best way to take her medicines and that she tries to take them properly. Eileen's heart disease causes frequent visits to the hospital. Any amendments made to her dosages on these visits are noted on the patient held medication record and her community pharmacy updates this on her next visit. Tools such as this and interaction between Eileen's multi disciplinary team have helped prevent her from any recent admissions to the emergency department or hospital.