

Practice Spotlight: Emergency Department Pharmacist Who Makes House Calls

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Gordon Matthies maintains 2 half-time positions that meld cohesively to provide a working model of seamless care. Combining these positions with Alberta's additional prescribing authorization has allowed Mr Matthies to provide timely pharmaceutical care for patients while improving communication among hospital physicians, family physicians, and community pharmacists.

Mr Matthies' first position is within the Red Deer Primary Care Network. In each of Alberta's 40 Primary Care Networks, a group of family doctors works with Alberta Health Services and other health care professionals to coordinate the delivery of primary health services for their patients.¹ For this position, Mr Matthies maintains an office within the family physician's suite of offices, where he can meet with patients for an hour or more, accessing computers and chart notes as required. This collocation affords him the opportunity to discuss a patient's case face-to-face with the family physician, enter notes directly into the chart, and refer the patient, as necessary, to other providers within the Primary Care Network for management of hypertension, diabetes education, counselling on smoking cessation, and other services. One unique aspect of this pharmacist position is the capacity to make house calls, which can significantly increase patients' comfort and willingness to express concerns about their health and medications.

Mr Matthies' second half-time position is within the emergency department of the Red Deer Regional Hospital Centre. This position was created to help deliver pharmacist coverage in the emergency department 7 days a week (Mr Matthies is 1 of 3 pharmacists working in this capacity). It was initially set up as a pilot project to assist home care nurses in reducing unnecessary visits to the emergency department, including repeat visits, and to decrease the burden of inappro-

priate demand on the emergency department (as described in an internal document entitled, "Red Deer Re-Direct Emergency Project: Emergency to Home—A Senior's Journey to the Right Care"; Red Deer, Alberta). The subset of patients targeted through this project for attention from the emergency department pharmacist consists of elderly patients; however, any patient may be assessed by the pharmacist if a medication concern is suspected by any of the health care professionals involved in the patient's care.

In a scenario that is often encountered in emergency departments, an elderly person experiences a fall that may be due, at least in part, to an adverse drug reaction. Such falls are the most common cause of nonfatal injuries and hospital admissions for trauma.² In Red Deer, the home care nurse and pharmacist, along with the attending physician, will see the patient in the emergency department and may identify some medication-related concerns. At this point, it would be a simple matter to discontinue any potentially causative agents (for example, oxybutynin or amitriptyline) and send the patient home. However, an abrupt discontinuation of medications by staff in the emergency department may cause several problems for the patient, including loss of any benefit the medication could have been providing. If another agent is initiated in the emergency department, there is always a risk of the patient misunderstanding the new directions and taking the wrong medications once at home, or the possibility of confusion about instructions for titrations up or down, or the chance that other health care providers, such as the family physician or community pharmacist, will be unaware of the intended change. The presence of a pharmacist with experience in the emergency department, along with the capability to document information in the family physician's patient chart and perhaps even do a home visit, reduces the risk of these problems.

When cases like this occur at the Red Deer Regional Hospital Centre, the patient is interviewed and assessed by the on-duty emergency department pharmacist, who sends a referral for follow-up through the Primary Care Network. A home visit by Mr Matthies is used to address concerns about home medications, such as actual medication usage, medication hoarding, improper administration, and inappropriate storage,

as well as to ensure that the care plan developed in the emergency department is progressing appropriately; an overall medication review is also performed. Mr Matthies can assess the ramifications of discontinuing a medication, and, if appropriate, he can prescribe, titrate, and monitor an alternative medication. He then enters notes into the patient's chart in the family physician's office, including details about the visit to the emergency department, changes to medications, other referrals, and the ongoing follow-up either requested for or being provided to that patient.

Alberta's additional prescribing authorization has helped Mr Matthies' patients and the physicians with whom he works in various ways, depending upon the site where he uses this authorization. In the earlier example of an elderly patient using oxybutynin, the pharmacist can prescribe other alternatives, if appropriate, since asking emergency department physicians to manage conditions such as chronic urinary incontinence is not an appropriate use of their skills. In another example of how additional prescribing authorization is used within the Red Deer hospital, the emergency department pharmacist receives all culture and sensitivity reports, usually 2 or 3 days after the patient presents to the emergency department. The pharmacist reviews the results, along with documentation about the visit and appropriateness of the antibiotic provided. If a change in therapy is required on the basis of test results, it is the pharmacist who contacts the patient, makes the prescribing decision, contacts the pharmacy with the new prescription, and documents the decision and rationale. Having the prescribing pharmacist make changes to the medication regimen streamlines the process and can significantly improve documentation and communication for everyone involved.

Mr Matthies can also write prescriptions in his Primary Care Network position, which improves timely patient care in the community. However, this additional prescribing authorization does not mean that the pharmacist works in isolation. Mr Matthies almost always has some communication with the primary physician involved in the patient's case, in addition to chart notes, and the team has usually set the general direction for the patient's care. Sometimes this direction is set or changed as a result of an adverse drug reaction that brought the patient to the emergency department in the first place. Mr Matthies'

prescribing authorization means that he can make medication changes as necessary to move the care plan forward, perhaps according to lab results, adverse drug reactions, drug plan issues, or unique patient factors, and then communicate those changes to the physician.

The benefits of having a pharmacist in the emergency department 7 days a week has helped to change this emergency department pilot project into a fully funded permanent position. The home visit and documentation components afforded by having the Primary Care Network pharmacist position co-located in a family physician's office have helped to improve medication management and patients' understanding of their medications. The combination of the 2 positions should contribute to a reduction in repeat visits to the emergency department caused by communication misunderstandings, both between patients and health care providers and among health care providers.

References

1. Primary care initiative. Edmonton (AB): Alberta Health Services; 2011 [cited 2012 Feb 20]. Available from: www.albertapci.ca/Pages/default.aspx
2. Falls among older adults: an overview. Atlanta (GA): Centers for Disease Control and Prevention; [cited 2012 Feb 20]. Available from: www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html

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The Practice Spotlight series highlights the accomplishments of Canadian pharmacists with unique practices in hospitals and related health care settings. If you have a unique or innovative practice, or you know someone else who should be profiled, please submit your contact information to Mary Ensom, Editor of *CJHP* (cjhpedit@cshp.ca), and one of our Associate Editors will be in touch with you.