A guide for pharmacy teams

Why not home? Why not today?

Evidence shows it's much better for a patient's physical and mental wellbeing to leave hospital as soon as they are medically optimised for discharge.

This is why it's really important we do everything we can to enable our patients, particularly older people, to continue their recovery in their own home environment or, for those few who cannot go straight home from hospital, within a care location most suited to their needs.

You have an important part to play in making this happen. And there are a number of practical actions you can take to help get patients to the best place for them.

The evidence

There's lots of evidence to show that patients recover better at home once their treatment in hospital is complete. Patients who stay in hospital longer than is necessary may face issues including:

- **35% of 70-year-old patients experience functional decline** during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%.[1]
- **48% of people over the age of 85** die within one year of hospital admission.[2]
- Exposure to the risk of **healthcare-associated infections.**

[1]Guide to Reducing Long Hospital Stays, June 2018.

[2]Imminence of death among hospital inpatients: Prevalent cohort study. David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, 17 March 2014.

How you can make a difference

NHS England and NHS Improvement has worked with a number of partners to identify five key principles which can help ensure that patients are discharged in a safe, appropriate and timely way.

The principles relate to different stages of a patient's stay: some to the moment of admission, some to their time on a ward and some to the end of their stay.

1. **Plan for discharge from the start**
2. **Involve patients and their families in discharge decisions**
3. **Establish systems and processes for frail people**
4. **Embed multidisciplinary team reviews**
5. **Encourage a supported home first approach**

Underneath each key principle are specific actions that you can take as pharmacy teams.

By following these actions and thinking **"Why not home? Why not today?"** every day, we can reduce length of stays and get patients to the best place for their recovery.

1. Plan for discharge from the start

- Start preparing for discharge at admission, or pre-admission if elective.
- Think "Why not home? Why not today?" every day.
- Consider the need for medicines supply at discharge. Not all patients need further medicines.
- Work closely with ward staff to understand the Expected Date of Discharge (EDD) and anticipate any medicinal requirements that may impact on this.
- Reduce discharge prescription and medicine processing time. Think minutes, not hours, between receiving a discharge prescription and the patient leaving the hospital.
- Discharge prescriptions should be planned, written, processed and available on ward in advance of the EDD for all planned discharges.
- Use separate pharmacy workflow streams for urgent work and non-urgent work. For example, discharge medicines and routine work. Maintain flexibility to respond to increased demand.
- Implement seven-day clinical pharmacy services and provide technical support to high admission and discharge areas to reduce delays to discharges over the weekend and on Mondays.

2. Involve patients and their families in discharge decisions

- Wherever possible, support patients to manage their own medicines while in hospital.
- Consider ways to reproduce how medicine will be administered at home; how it works in hospital may be very different to how it works for people once they are at home.
- Ensure the pharmacy team are aware of all patients with blister packs and try to minimise last minute changes to medicines in this group. The person should be assessed for their need of a monitored dosage system before being discharged.
- Integrate pharmacy teams across the local health economy (including community pharmacists) to optimise medicine-related discharge processes, ensure safe transitions of care and reduce readmissions. This will include developing links to Care Homes, GP Practices and Primary Care Networks.
- Use the Transfers of Care Around Medicines (TCAM) process.
- Ensure any medicine changes during admission are discussed with the patient prior to their EDD to reduce risk of medicine errors at home. Changes include: new medicines, changed doses or discontinued medicines.

3. Establish systems and processes for frail people

- Establish if patients are managing to take their medicines at home. Do they have, or need, support with medicines on discharge? Do they need additional aids or support such as non-childproof tops, etc.?
- Encourage follow-up in the community by the community pharmacist.
- Optimise medicines, considering the contribution of medicine-related adverse effects to risk factors, like risk of falling.

4. Embed multidisciplinary team reviews

- Contribute to multidisciplinary team reviews and ward and board rounds.
- Ensure medicine-related issues are clearly communicated to the multidisciplinary team and medicines are optimised in advance of the EDD.
- Identify and communicate any medicine-related supply, monitoring or follow-up requirements that are likely to impact on discharge early on, so a plan can be made in advance of the EDD.

5. Encourage a supported home first approach

- Ensure that the patient, their carer or a family member can manage their medicines when at home.
- Work with the multidisciplinary team to support facilitating intravenous medicines administration out of hospital. For example, through Outpatient Parenteral Antimicrobial Therapy (OPAT), homecare or day-case or infusion centres.