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P262 -Medicines Optimisation in maintenance haemodialysis patients – Survey of UK renal units

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Introduction
Medicines optimisation is a priority for the NHS due to a number of factors including; 30-50% of medicines are not taken as intended1, 5-8% of hospital admissions are related to medication issues2, patients transferring between care providers have a 30-70% risk of medicines error or unintentional medication changes3.
Medicines optimisation is particularly important in patients undergoing maintenance haemodialysis (HD), as they often take multiple medications, are managed by several care providers and include an increasing number of frail patients. Pharmacists can provide leadership and support for the implementation of medicines optimisation4.
The NHS England Standard Contract for Renal Dialysis Hospital and Satellite states that 'Patients should receive a regular scheduled formal medicines management review and this should be done routinely whenever a patient changes clinical locations for their care.'
Currently, there are no national guidelines for pharmacy service provision or staffing levels for HD units. The 2002 UK Renal Pharmacy Group (RPG) workforce planning guideline is currently under review in association with the British Renal Society (BRS).
In this survey we sought to clarify the current levels of pharmacy service to maintenance HD patients across UK renal units.

Methods
An electronic survey was distributed via RPG and the Shelford Group network. The survey aimed to identify levels of clinical pharmacy services delivered to HD patient across UK renal units. Pharmacy services included input from pharmacists and pharmacy technicians.

Results
Nineteen renal units responded to the survey. The number of dialysis units under the care of each organisation ranged from 1 to 10, with an average of 4.5 units. The total number of haemodialysis patients in each organisation varied from 70 to 1440.
Pharmacy service to HD units varied significantly between organisations. 42% of organisations had no established pharmacy service to HD units, whilst 31% of organisations received an average of 7.5 hours or more of dedicated pharmacy time each week (median 2 and 0 pharmacist and pharmacy technician hours respectively).
Roles undertaken by pharmacy staff varied between units. Most pharmacy services are provided on an ad-hoc basis, the most common of which were provision of patient education (in 89% of organisations), nurse education (89%), clinical review (58%) and medicines reconciliation following discharge from hospital (53%). Less than half (47.4%) of organisations surveyed deliver any clinical pharmacy services to HD units on a regular basis.
HD patient groups most commonly prioritised for pharmacy input were; inpatients, doctor and nurse referrals and patients new to HD.

Discussion

HD patients often have multiple co-morbidities, managed by several care providers and take multiple medications. These patients would benefit from medicines optimisation approaches to reduce the risk of medicines related harm, maximise treatment efficacy and reduce medicines waste. Pharmacists have the skills and knowledge to apply medicines optimisation in the management of HD patients. At present, pharmacy services to UK maintenance HD patients are limited and variable. The skills and knowledge of pharmacy professionals could be better utilised to improve the management of maintenance HD patients.