East Lancashire Hospitals NHS Trust

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refertopharmacy

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Case Study of Hosptial Discharge and a anticoagulant medicine

Alice was admitted to the Royal Blackburn Hospital with what turned out to be a gastric bleed. It was determined that the cause of the bleed was her Rivaroxaban tablets, this is a type of medicine known as a DOAC, which is an anticoagulant; and it was stopped. Alice was also given a course of intravenous omeprazole to fix the bleed.

When her transfer of care letter was prepared for her discharge from hospital, it clearly stated what had happened and that the DOAC had been stopped. The ward pharmacist made a referral via Refer-to-Pharmacy scheme for a post-discharge Medicine Use Review, in the knowledge that the scheme would inform Alice's community pharmacy of this change, and share a copy of her transfer of care letter.

Alice was discharged from hospital and for whatever reasons her GP's practice issued a regular repeat of the Rivaroxaban tablets and sent it to her community pharmacy.

This prompted the community pharmacist to telephone the surgery to find out what was happening, as they understood that the DOAC for Alice had been stopped. The surgery staff checked their records and confirmed that the Rivaroxaban prescription was an unintentional error and the DOAC was not dispensed.

Before Refer-to-Pharmacy existed there would have been no communication from the hospital to the community pharmacy; the pharmacist would have been oblivious to the hospital admission and the stopping of the DOAC and would have legitimately made the supply... and Alice would in all likelihood have had another GI bleed and potentially died.

Because of Refer-to-Pharmacy and the behaviours exhibited by the hospital and community pharmacy teams, no harm came.