West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

DMS target patient groups

Information for community pharmacy teams October 2024

All Trusts in West Yorkshire refer specific patient groups to the Discharge Medicines Service (DMS) following discharge from hospital. DMS is an essential service and as such all community pharmacies must provide the service when they receive a DMS referral from a Trust. Referrals from West Yorkshire Trusts are usually sent via PharmOutcomes but Trusts outside of West Yorkshire (and occasionally Trusts within West Yorkshire) may use NHSmail to refer.

Trusts have been working to expand the patient cohorts that will be targeted for a DMS referral and community pharmacies may now start to receive referrals for patients:

- Prescribed a liquid medicine
- Discharged with a short-term opiate for pain relief
- Previously or currently prescribed an anticholinergic

This briefing aims to outline the rationale for a DMS referral for these groups of patients.

Drugs with Anticholinergic Burden (ACB)

Anticholinergic effects are associated with increased risk of cognitive impairment, falls and all-cause mortality in the elderly. Not all medicines with anticholinergic properties may individually put patients at risk of severe adverse effects, however when used in combination, effects may accumulate. Anticholinergic burden (ACB) refers to the accumulated effects of medication with anticholinergic properties, resulting in symptoms such as confusion, urinary retention and constipation. Reducing the anticholinergic burden may result in improvements in these side effects and result in a reduction in hospital readmissions and better outcomes for older patients.

Examples of medications with a high anticholinergic burden include;

- Oxybutynin
- Amitriptyline
- Solifenacin
- Chlorphenamine
- Sertraline
- Promethazine
- Tramadol
- Benzodiazepines

Trusts are working to identify patients with high anticholinergic burden (measured as an ACB score) for review of medications. This may lead to patients being discharged on a reduced dose, a reducing dose or no longer prescribed a drug with anticholinergic effects. These changes to medication may be flagged up to community pharmacies via a DMS referral.

Within a DMS, community pharmacies can facilitate the discontinuation of drugs with anticholinergic effects by;

- Supporting patients in understanding why their medications have changed including following any tapering regimes.
- Ensuring that the prescription from the GP practice does not unintentionally restart or increase doses of medicines that have been stopped / reduced in hospital.
- Being aware of withdrawal symptoms for recently stopped medications. When discontinued suddenly, anticholinergics are commonly associated with adverse effects including anxiety, nausea, vomiting, dizziness & headache. Where these symptoms are reported the

pharmacist should manage appropriately, which may include referral to the GP Practice to review the pace of withdrawal (anticholinergics should be slowly withdrawn).

Dependence Forming Medicines

The NHS Framework Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms: Framework for action for integrated care boards (ICBs) and primary care aims to support a whole systems approach to medicines associated with dependence or withdrawal symptoms.

NHS trusts are encouraged to use DMS for patients newly started on opioids (eg after surgery) and other medicines associated with dependence and withdrawal symptoms to minimise risk of long-term use and give patients extra support. The DMS may even be for a patient who is not expected to continue the medication following the course supplied by the Trust.

Within a DMS, Community pharmacies can facilitate the discontinuation of dependence forming medicines by;

- Supporting patients in understanding the length of course (e.g. short-term opioid for pain relief) including following any tapering regimes.
- Ensuring that the prescription from the GP practice does not unintentionally restart medicines that were prescribed as short courses.
- Advise patients about their dependence forming medicines to help improve safety.
- Take a proactive approach and highlight excessive/unusual doses.

Liquid Medicines

Liquid medicines at discharge can present a greater risk to patient safety over solid dose forms for a number of reasons including:

- Errors/confusion regards strength / volume of dose
- Conversion from solid dose
- Quantity supplied
- Formulation choice (alcohol content in children, sugar content in diabetics)
- Measuring difficulties (patients)
- Storage requirement (including shelf life once open)

Within a DMS community pharmacies can reduce the patient safety risks by considering:

- Supporting patients where the prescribing of liquid medicines was just temporary, and they are returning to solid dose formulations.
- Check any changes in formulation have been converted accurately, paying particular attention to strength and volume.
- Counselling on the dose to be taken/given and the importance of checking the strength supplied. It can be helpful to ask to see the label on the discharge medication where the patient brings this into the pharmacy.
- Ensuring the patient has the correct delivery device, and is able to measure and administer the medication safely. This includes ensuring you have in stock 1ml oral medicine syringes to support patients with small volumes and during counselling demonstrate the markings on the syringe.

- Signposting patients/caregivers to relevant resources/literature which may assist them with their medicines such as the Paddington resource for parents and carers taking babies home with medicines.

Resources linked to liquid medicines

Using Standardised Concentrations of Liquid Medicines in Children
NPPG-Position-Statement-18-01-V9-July-2023.pdf
The Neonatal and Paediatric Pharmacy Group (NPPG) and the Royal College of Paediatrics and Child Health (RCPCH) strongly recommend that when children require unlicensed liquid medications, they should receive the RCPCH and NPPG recommended concentrations, where one exists. There are currently 12 such recommended concentrations detailed below, 11 of which are published in relevant drug monographs of the BNF for Children. Some medicines from the original version of this list have been removed as licensed preparations are now available. By standardising the prescribed concentrations of these medicines, we will reduce the risk of errors being made in the doses given to children and prevent hospitalisation from accidental under and overdoses.

General Pharmaceutical Council: Patient safety spotlight: the risks of prescribing and supplying medicines to children, October 2021
Patient safety spotlight: the risks of prescribing and supplying medicines to children | General Pharmaceutical Council (pharmacyregulation.org)

Great Ormond Street Hospital for Children
Medicines Information for Children
http://www.gosh.nhs.uk/conditions-and-treatments/medicines-information

Leeds Teaching Hospitals Medicines Formulary Group & The Yorkshire & Humber Congenital Heart Disease Network Board & West Yorkshire ICS: Recommended Standardised Formulations in Paediatric Cardiology, October 2021
24.02RecommendedStandardisedFormulationsInPaediatricCardiology.pdf (leedsformulary.nhs.uk)

Medicines for Children: A partnership programme of Royal College of Paediatrics and Child Health (RCPCH), Neonatal and Paediatric Pharmacists Group (NPPG) and WellChild. This includes practical advice about giving medicines to children
www.medicinesforchildren.org.uk

PADDINGToN a resource to help parents and carers with a baby on medicines
These resources were produced by parents and healthcare professionals who took part in the PADDINGToN study (PArent co-Designed Drug INformation for parents and Guardians Taking Neonates home).

The Neonatal and Paediatric Pharmacy Group (NPPG) and the Royal College of Paediatrics and Child Health (RCPCH): Excipients and Choosing an Oral Liquid Medicine for Children
Position-Statement-Liquid-Choice-V1-November-2020.pdf (nppg.org.uk)
Editorial (infantjournal.co.uk)