

Improving clinical monitoring and governance of the renal homecare service for erythropoietin stimulating agents: a quality improvement project

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Background

An internal review of the erythropoietin stimulating agents (ESAs) home delivery service for renal patients revealed a number of quality issues such as use of hand-written prescriptions leading to errors and illegibility and inconsistencies with the registration process and inadequate data management. Also, there was no pharmacy involvement to support clinical assurance and adherence to best practice recommendations and to the Royal Pharmaceutical Society professional standards for homecare services (1). The review also revealed one of the 2 existing homecare providers was not included in the East Midlands technical contract, which would undermine the region's tendering processes and potentially lead to financial penalties. Another key driver for change was the Trust's requirement to collect patient level data in order to achieve the Medicines Optimisation CQUIN. As a result of these findings, a series of changes were introduced as a quality improvement project.

Method

The project was led by the homecare and pharmacy teams and a business case was approved for additional pharmacy resource. A process map detailing the ESA homecare provision was created to summarise the current position. After identifying and consulting with key stakeholders, processes were refined and finalised, resulting in a detailed action plan and timeline to undertake the transition to a new ESA homecare service, fully compliant with relevant regulations. This plan involved creating new patient communication and information materials and transitioning of all affected patients to a homecare provider on the East Midlands contract. All patients were registered with written consent obtained using nationally approved homecare documentation. Newly designed prescriptions in electronic format were introduced which were clinically screened by a pharmacist. Secure prescription transport arrangements were introduced and prescription data management and invoice processing were carried out by the pharmacy homecare team.

Results

The project was successfully completed within the agreed time scales with no incidents, no missed deliveries or disruption in medication supplies as a result of the transition. The pharmacist clinical screening process of all prescriptions has provided additional quality assurance by identifying inappropriate prescribing (e.g. patient passed away, haemoglobin above target) and liaising directly with prescribers to resolve these issues. Patient level data is collected consistently, providing robust audit trail. In addition, the involvement of the homecare pharmacy team has provided additional financial governance through contractual price adherence and invoice management. This was a cost-neutral exercise in terms of drug acquisition and delivery costs.

Discussion

Implementing the new service has led to closer integration of teams (clinical, administrative, pharmacy teams, managers, patients groups and homecare providers). The inclusion of the renal and homecare pharmacy teams has improved patient safety and governance of the service. A full patient and prescription

dataset has facilitated internal audit and evaluation of the service. It will also be used to inform future commissioning reviews and further quality improvement work.