ARRS Impact January 2024 – Patient stories

Patient stories
Clinical Pharmacist a): A patient with multiple co-morbidities and uncontrolled Diabetes was referred to the pharmacist. She presented with many medication side effects and raised HbA1c and BP. The pharmacist over multiple appointments trialled varying medication and significantly reduced her side effects but was unable to control her diabetes to an appropriate level. She was referred into the diabetic clinic who altered medication and caused the return of these side effects with significant distress to the patient (who then did not wish to return). The pharmacist in consultation with secondary care and with the aid of the PCN lead diabetic nurse, initiated insulin and monitored the patient's titration. This would not have been possible at this surgery without the ARRs. This particular patient has adverse reactions to many anti-hypertensives and hypoglycaemics and it has been invaluable to have the pharmacist's medication knowledge. The patient also felt she had better individual care at the surgery and the pharmacist prevented many GP appointments. Clinical Pharmacist b) I have recently been asked by a GP to review a patient's medication with respect to her kidney function. She is a 76-year-old double amputee patient (since 1995) with CKD 'stage 3b' from last eGFR (35ml/min in September 2023 and 35ml/min in October 2023). We do not have a recent weight, so unable to calculate creatinine clearance. I was concerned that eGFR (and CrCl) are not accurate in amputee patients. I discussed this with her GP and we decided to use eGFR as a guide to how kidney function is progressing. It has shown a gradual reduction over the past 5 years (average decrease by 5 ml/min every year). I contacted a renal specialist pharmacist in secondary care and agreed a suitable plan. I reviewed her meds and made several changes to both doses and drug treatment, with patient's consent, using BNF, Renal Handbook 5th edition and SPCs as resources (implying her eGFR to be accurate). As part of a UTI prophylaxis audit, her cefalexin treatment for the past 10 years was stopped as a trial, and to monitor symptoms and contact practice if any sign of UTI. Bloods were taken after 4 weeks and her eGFR seems to have improved slightly to 44ml/min. Blood monitoring agreed to test every 12 weeks ongoing. (BP, lipids, LFT and HbA1c also to be monitored) The additional role has enabled this patient to have better care of her medication and kidney function possibly avoiding hospital admissions while relieving the pressure otherwise put on other practice clinicians. During this review antibiotic prescribing was reduced and a polypharmacy review undertaken to reduce unnecessary medication prescribing. SPLW Referrer - ABL Smoking Cessation Service. Patient was feeling **panic** when trying to leave their home, **becoming housebound**. They had lost their usual social activities and were **struggling at home with personal care**, forgetting to take medication, struggling with **weight management** and with changing their GP surgery. Patient also disclosed concerns with **debt and financial difficulty**. Through a person-centred approach, the patient was supported to explore the multiple, competing **stressors** that were impacting on daily life. Support was requested with gradually building a good **routine** again, so a variety of local groups and activities were identified together. These services needed to be close to home as the patient struggled with **mobility**. The patient was enabled to attend groups at Wirral Mind, and this became a core part of a weekly routine. **Weight management** options were discussed, and the patient was referred, with consent to the **PCN health coach**. This resulted in the development of a food diary and exercise plan. Contact was made with **adult social care** and an appropriate **care package** was put in place to

ensure the patient was **safe in their home**, to support with the morning bath and breakfast preparation and able to administer medication appropriately.
A specialist **Advisor from AskUsWirral** was able to put a plan in place to **resolve their debt** and manage finances.
The client was also signposted to her closest GP as her previous practice was too far away for them to travel to comfortably. They are now able to walk to their GP.

Impact of actions

- Reduced likelihood of hospital admission due to inappropriate administration of medicine
- Reduced likelihood of GP appts or hospital admission due to poor diet and lack of exercise
- Reduced likelihood of hospital admission due to lack of income/poor financial health

Feedback from the patient

I no longer feel housebound and have managed to regain my old routine which I had lost. They felt that the support at home would start their day right and gave them the confidence to head out in the morning to attend their usual activities.
The patient also felt that a weight was lifted after receiving support with finances. They felt motivated to monitor their food intake, and to incorporate healthier foods into their diet. They also incorporated the walk to their new GP into their routine, increasing the frequency of exercise.

SPLW

Healthier South Wirral PCN - Case stu

Mental Health Practitioner

Patient having trouble in accessing support and treatment as a result of the symptoms of his mental illness. Liaised with Secondary services and provided a rationale for the transfer of care directly to the CMHT meaning the often-lengthy referral to the access team could be avoided. The patient was accepted by the CMHT and a care coordinator appointed to manage his access to treatment and provide any required support. The patient is now in receipt of an appropriate level of care and is responding well to same.
Patient experiencing depression, anxiety and intrusive thoughts, suicidal ideation, and poor self-esteem. Through a process of elimination via diary keeping and psychosocial and physical intervention determined symptoms were consistent with PMDD. Pt is also peri menopausal. Pt commenced appropriate HRT and Antidepressant. MH symptoms have reduced, and patient feels supported.

Patient from out of area was staying with relatives. He was stable in the community, but his mediation needed reviewing in line with current physical symptoms. I was able to liaise with out of area GP to obtain full history, obtain specialist consultant level medication advise around changes. I was able to complete a succinct and comprehensive mental health review within his GP practice/primary care setting.