Joint Position Statement between UK Clinical Pharmacy Association and the Royal College of Emergency Medicine regarding Pharmacists & Pharmacy Services in Emergency Departments

Updated December 2023

Introduction

Patients presenting to the Emergency Department (ED) are increasingly complex, with multiple co-morbidities and significant polypharmacy. Pharmacy services are uniquely qualified to ensure safe and effective use of medicines, improving quality of care, and reducing unnecessary costs and treatment delays.

Pharmacists optimise medication use in the acutely unwell patient, improving prescribing quality and safety, factoring in instability and complexity of medicines used in this patient group using evidence-based recommendations, and collaborating with medical and nursing teams. In comparative studies, proactive reconciliation and optimisation of both acute and chronic medicines by pharmacy teams in patients presenting to the Emergency Department has been shown to reduce medication errors and improve outcomes for patients [1]. Evidence supporting the use of ward-based pharmacy services from admission to discharge in Emergency and acute care shows clinical and economic benefits with significant cost savings [2]. NICE recommends inclusion of pharmacists in the multi-disciplinary care of patients requiring emergency admission to the hospital [3].

Pharmacy Technicians and Assistant Technical Officers (ATO) provide invaluable expertise in medicines management, expenditure reporting, and practical medication advice. Their supporting and direct patient-facing roles allow pharmacists more time to undertake medicines optimisation.

RCEM recommends the use of dedicated Emergency Department pharmacists and pharmacy services to work as part of the multidisciplinary team to help support the safe and efficient delivery of care to patients in the Emergency Department as well as in Clinical Decision Units / Observation wards.

Incorporated by Royal Charter, 2008
Registered Charity Number: 1122689
VAT Reg. No. 173205823
Scottish Charity Number: SC044373

Standards

1. All Emergency Departments must have a dedicated pharmacist. For clinical cover, RCEM recommends 0.1 WTE pharmacist per Resus bed plus 0.05 WTE pharmacist per Majors/High Acuity bed. This calculation should include patients managed in non-clinical areas (e.g. corridors) who would otherwise be in Majors/High Acuity beds.
2. All Emergency Departments must have a dedicated Pharmacy Technician. RCEM recommends 1 WTE as a minimum however, there should be sufficient allocated Pharmacy Technician and ATO time to provide supporting roles and assist in medicines management relative to the size and complexity of the ED.
3. Co-located observation wards / Clinical Decision Units should have a dedicated pharmacist supplementing the dedicated ED pharmacist to cover the area. This resource should be sufficient to ensure medicines reconciliation occurs within 24 hours of patient arrival to ED and ensure efficient and coordinated discharge.
4. The Emergency Department pharmacy service should be present seven days per week. As a minimum, the service must be available five days per week, and plans in place to increase to seven days per week by 2025 [4].
5. The ED pharmacist must have a job plan and support to allow sufficient time to be dedicated to all aspects of the role. There should be sufficient pharmacy team resources available to support non-patient facing activities as part of the ED management team.
6. ED pharmacists should be working towards or have achieved accreditation on the RPS Advanced Specialist Curriculum, Advanced Pharmacy Framework, or equivalent. Other pharmacists working in the ED should be engaging with a relevant curriculum, have appropriate skills and experience, and have access to the ED pharmacist for clinical support [5,6].
7. RCEM does not support the use of pharmacists without additional training to see ED patients independently except for issues directly pertaining to the usage of medicines.

Recommendations

1. Sufficient resources should be provided to cover annual, sickness, and educational leave periods to ensure continuity of service to ED patients. This may be best achieved via the use of a pharmacy team rather than individual practitioners.
2. In times of escalation and reduced patient flow from ED, additional pharmacy service resources (pharmacist or pharmacy technician) should be made available to reduce the risk of patient harm [7]. RCEM recommends, where required, an additional 0.05 WTE pharmacist or pharmacy technician per occupied corridor/overflow bed OR 0.05 WTE per patient waiting 12 hours or greater in the ED.
3. If not already resourced, the ED pharmacist should also provide clinical and operational support to any Emergency Department operated separate Urgent Treatment Centre.
4. Emergency Department pharmacists should be supported and encouraged to become active independent prescribers in Emergency Medicine and maintain appropriate Consultant / SAS clinical supervision.
5. Pharmacy Technicians should be experienced in working with acutely unwell patients and appropriately certified to take histories and reconcile medicines.

Background

The following are examples of core duties of the Emergency Department pharmacy service and should be considered when designing and implementing team structures:

- **Medicines reconciliation and treatment optimisation** – ensuring an accurate drug list is available and acute/chronic treatments optimised as soon as a decision to admit has been made, aiming to reduce the length of hospital stay.
- **Focus on high-risk patient groups** – patients who are elderly (STOPP/START Tool; a medication review tool), have renal failure, or a disease requiring time-critical medication to manage to help ensure these patients do not deteriorate whilst in the Emergency Department or if subsequently admitted; as well as considering drug interactions. The promotion and monitoring of safe prescribing in children.
- **'Ward-based' activity** – anecdotally, pharmacy cover has been scanty for Clinical Decision Units / Observation Wards; the rapid turnover often complex patients (e.g. older patients after a fall, awaiting therapy or social input) may result in issues with drug prescription and administration, as described above.
- **As part of the ED management team** – drug budget analysis, safe management of controlled drugs, development of guidelines/drug monographs, prescription charging, liaison role with the rest of hospital regarding medicines policies and impact upon the Emergency Department, electronic prescribing, and 'automated' dispensing.
- **Patient safety** – embedded in clinical governance as part of the ED management team, prevention, and reporting of drug errors, drug safety alerts, review, and advice regarding high-risk medicines such as warfarin, insulin, and anti-cancer agents, and promotion of safe prescribing. Ensuring time-critical medications are prescribed and administered correctly, providing alternative plans for those patients.
- **Clinical decision support** – for Emergency Department professionals encompassing safe prescribing, drug location, and drug administration. Specific issues for the Emergency Department include antidote availability compliance with national guidance relating to pharmaceuticals (e.g. recalls). Pharmacists have a key role in staff education on the use of medicines.
- **Dispensing of prescriptions** – rapid access to palliative care discharges, fast tracking of prescriptions for patients waiting to be discharged, to avoid breaching emergency access standards ('4-hour target'), particularly if the hospital pharmacy is located some distance from the Emergency Department.
- **Patient education** – new drug prescriptions, inhaler technique, use of injector pens.
- **Liaison with primary care** – to provide feedback to general practitioners regarding their patients who have attended the Emergency Department and who may be on less than optimum drug therapy (too many, too few, wrong ones) irrespective of presenting complaints and to coordinate complex changes at the point of discharge.

References

1. What is the evidence that a pharmacy team working in an acute or emergency medicine department improves outcomes for patients: A systematic review. Punj et al., 09/2022. https://bpspubs.onlinelibrary.wiley.com/doi/full/10.1002/prp2.1007
2. Emergency and acute medical care in over 16s: service delivery and organisation, NICE, 2018. https://www.ncbi.nlm.nih.gov/books/NBK564916/
3. Chapter 30 Pharmacist support: Emergency and acute medical care in over 16s, NICE guideline 94, 03/2018. https://www.nice.org.uk/guidance/ng94/evidence/30.pharmacist-support-pdf-172397464669
4. Transformation of seven day clinical pharmacy services in acute hospitals, NHS England, September 2016. https://www.england.nhs.uk/wp-content/uploads/2016/09/7ds-clinical-pharmacy-acute-hosp.pdf
5. Royal Pharmaceutical Society Advanced Practice Curriculum, RPS. Core Advanced Executive summary.pdf (rpharms.com)
6. Royal Pharmaceutical Society Advanced Pharmacy Framework, RPS. RPS Advanced Pharmacy Framework.pdf (rpharms.com)
7. Harm caused by delays in transferring patients to the right place of care, HSIB 08/2024. https://bpspubs.onlinelibrary.wiley.com/doi/full/10.1002/prp2.1007

RCEM Details:

Patron: HRH Princess Royal

Address:
Octavia House
54 Ayres Street
London
SE1 1EU

Tel: +44 (0)20 7404 1999
Fax: +44 (0)20 7067 1267
www.rcem.ac.uk