Charlene arrives at work at 8am and from the office in the Pharmacy Dept. logs into the Acute EHR to get an overview of the inpatients under the care of the Age-Related Healthcare specialty. The Acute EHR provides quick and easy access to information about this cohort of patients that enables Charlene to prioritise the patients that she will need to review.

Charlene can see that there was a new admission to the Acute Stroke Unit about an hour ago and she will need to lead on the medication history taking and reconcile this against the inpatient prescription chart. A lady in the Rehab Stroke Unit has been prescribed a drug that has been deemed as a high risk to patient safety and Charlene needs to review this to confirm it has been prescribed safely with the appropriate administration instructions. A patient who came in after she had left yesterday has been prescribed some medications and her own supply will be used during the inpatient stay so the prescription and supply need to be checked. Recent abnormal blood results for one of her patients have been flagged because the patient is on a medication that is contra-indicated in renal insufficiency. She can also see that there are 2 patients whose status has been updated as medically fit for discharge that she needs to see to progress their discharge medicines reconciliation and to counsel the patients on optimal use.
Charlene reviews the record of the patient with renal insufficiency and sends a message via the Acute EHR to the medical team with a recommendation for revised therapy due to the recent blood results.

She then checks the record of the patient that will be using their own supply whilst in hospital, reviews the details of the prescription, and assigns a task to the ward-based Pharmacy Technician to check the POD supply.

Next she checks that the high risk medication has been prescribed, and is being administered appropriately, before setting off to the wards to see the other patients.

She decides to see the recent admission first and the Acute EHR enables her to determine which bed he is in on the Acute Stroke Unit. John Black is a 70 year old man with Atrial Fibrillation. Earlier this morning his wife suspected he was having a stroke and called an ambulance. Charlene arrives at John’s bedside. John’s speech has been affected by the stroke so he is unable to provide any information himself and his wife has gone for a cup of tea. Charlene reviews the Shared Record to get an understanding of his medical history and management, noting that there was a recent DNA for a Cardiology appointment and that his last GP consultation was 3 months ago. She reads the information recorded by the ambulance, medical and nursing staff this morning and can see the investigations, observations and treatment regime to date. She notes that he is Nil By Mouth and a full swallow assessment is pending.

She uses information from his Shared Record to assist her in identifying the prescribed, over-the-counter and complimentary medicines John was taking before admission. She checks recent clinic letters and confirms that the medication details in these align with the prescribed list from the GP record. She checks the dispensing record and notes that the Community Pharmacist has not recently dispensed against the Apixaban prescription which may indicate he has not been compliant with taking his medicines.

Charlene uses the Acute EHR to reconcile the pre-admission medication list with the current inpatient prescription list. Discrepancies have been automatically highlighted and Charlene can see where reasons have been recorded by the medical staff; she notes what appears to be an unintentional discrepancy and uses the Acute EHR to collaborate with the medical team to resolve this. She also reviews John’s allergy record and ensures that the Acute EHR holds the most up-to-date information.

Charlene completes her pharmacological review of John and checks her EHR list again to see where her next patient is located. Siobhan Madden, a 65 year old lady who has been on the Acute Gerontology Ward for the last week is now ready for home. The medical team have completed her discharge medication list and Charlene now needs to reconcile this with the pre-admission list. Again the Acute EHR facilitates this process highlighting discrepancies which Charlene can see were intentional. She amends one item to clarify the formulation and another to indicate it should be taken before food. These changes are automatically sent to the medical team for counter-signature. She chats to Siobhan about the new medication she has been started on and provides information about the purpose, how to take it, potential side effects, etc. She checks if Siobhan has access to her own EHR and when this is confirmed she shares written details of all discharge medications to Siobhan’s record for her to read when she gets home. She confirms the details of Siobhan’s preferred Community Pharmacy and tells her that the prescriptions will be automatically communicated to them and her GP, and she should receive a text when they are ready for collection.

After saying goodbye to Siobhan she checks the EHR list again and noting that the other patient who requires discharge medicines reconciliation is currently off the ward she decides to come back to him later. She can see from her cohort list that the Digoxin
Levels are back for one of her patients so she reviews his chart to check if it is within the therapeutic range. The Acute EHR facilitates a review of the Digoxin Level, other relevant blood results and his vital signs and Charlene’s notes regarding her review.

She goes back to her cohort list on the Acute EHR again and sees that one of the nurses has asked her to provide some guidance to a patient on inhaler technique which she does, recording the details in the electronic record.

She can also see that one of the patients in her cohort has recently started enteral feeding so she reviews his current prescriptions, adds some notes on appropriate administration and flushing techniques, and makes a recommendation to the medical team to change the formulation of one of the medicines and to consider short term suspension of another non-essential medicine.

Charlene is undertaking an audit of missed and delayed medication doses on inpatients across all medical specialties in the Hospital Group. After lunch she spends an hour in her office using the Acute EHR to assist her with this audit.

At 2pm she goes to the Acute Stroke Unit for the afternoon round where the Acute EHR is used to support an MDT review of each patient. Siobhan undertakes a review of the inpatient drug chart for each patient seen, discussing options with the medical team and making changes as appropriate, which are added to the medical team worklist to be co-signed by a Doctor. Any pharmacy related follow-up tasks are added to her own worklist or assigned to the Pharmacy Technician.