**Discharge Medicines Service Local Masterclasses**

Community Pharmacy Devon recently ran two Discharge Medicines Service Masterclasses: one in Torbay and one in Exeter. We were fortunate to be joined by a series of speakers that ranged from Community Pharmacy, Hospital Trusts, the Devon Partnership Trust, PCN leads and in Torbay also we were lucky enough to be joined by intermediate care.

The workshop helped participants to discuss all of the processes from referral through to completion including an overview of what happens when the surgery gets a discharge notice.

What the discussions highlighted was that there is some duplication of work occurring in various settings; however, we are still seeing the interventions that are being raised which will be increasing patient safety. This in part is because as with dispensing, mistakes do happen!

What we found interesting from the sessions were the questions that were being asked. For example, as a community pharmacist can you link services together (e.g., DMS and the new medicines service (NMS)) and the fact that the hospitals were not aware of the NMS service in its entirety. Clarification was sought as to whether you can link to those conditions as well as the high-risk medicines or vulnerable patients.

Our aim is to constantly review progress being made locally, and to continue to bring the hospital teams into the discussions to learn and discuss their next steps.

The Devon Partnership Trust which covers much of the County apart from Plymouth are aiming to refer all of their discharged patients out to community pharmacy. Even if the referral is just for awareness of interactions on medications that may be prescribed and administered by the GP, it is hoped that this will ensure that community pharmacy teams have a full picture of what is happening and be able to give sound advice when looking at interactions.

After all the speakers had completed their presentations, there were lively discussions in breakouts where everyone had to work through seven scenarios to identify any errors, linking to NICE guidelines and increase understanding about how such errors may occur.

One example of an “error” discussed was that warfarin in three strengths had been stopped in hospital. On discharge a new prescription was allocated to the pharmacy, two strengths had been removed and one remained on the prescription. There were some great responses as to why this had happened from it being requested because the patient hadn’t taken the information in, to the practice not taking it off the repeat and it had been issued as the medication does not all fall at the same time as it is down to the INR results as to when the medication is taken and what dose.

We have built a FAQ document for you to look at to see what the most asked questions were and how we are working as a system to answer some of those questions.

The slides from the workshops can be found on the Community Pharmacy Devon website here <https://devonlpc.org/pharmacy-resources/resources-g-l/discharge-medicines-service-dms/>

Here are some useful links that to help support you through the DMS process.

* DPT medicines optimisation team email address: [dpn-tr.pharmacyteam@nhs.net](mailto:dpn-tr.pharmacyteam@nhs.net)
* Choice and Medication Website: <http://www.choiceandmedication.org/devon/>
* <https://devonlpc.org/pharmacy-resources/resources-g-l/discharge-medicines-service-dms/>

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