Pharmacist-led medication and rationalisation in a non-English speaking patient

Objective: Rationalise medications for an elderly non-English speaking patient using an onsite interpreter.

Key findings

1. The use of the Translating and Interpreting Service was crucial in providing quality patient-centred care
2. Using the Translating and Interpreting Service removed the language barrier and minimised the risk of worsening outcomes
3. Face-to-face translating services are underutilised in a clinical setting
4. The impact of translating services is difficult to measure. There are limited studies available that evaluate patients from a non-English speaking background

The details

2.4 – 3.6%

Hospital admissions in general patients are due to medication misadventure[2]

2x

Risk of medication error in non-English speaking patients[1]

Past medical history

- Uncontrolled hypertension
- Hyperlipidaemia
- Type 2 diabetes
- Renal impairment
- Hip and back pain

Clinical Features

An 87 year old female presented to the emergency department with ongoing epistaxis and malignant hypertension.

After initial treatment by the emergency team and an evaluation of her medications, she was flagged for discharge.

The emergency team ceased anti-inflammatory medications and suggested that she follow-up with her GP regarding her blood pressure medications.

However, there were complications and the discharge was unsuccessful. The patient was transferred to a medical ward.

Table 1: Medications on admission and reconciled for discharge

Medication	Route	Dose	Frequency	Status on discharge
Amlodipine	PO	10mg	mane	No change
Valsartan	PO	320mg	mane	Ceased
Hydrochlorothiazide	PO	25mg	mane	Ceased
Metoprolol	PO	100mg	bd	Reduced
Cholecalciferol	PO	2000 units	mane	No change
Rosuvastatin	PO	5mg	nocte	No change
Fenofibrate	PO	48mg	nocte	Ceased
Aspirin	PO	300mg	mane	Ceased
Aspirin	PO	100mg	mane	Ceased
Diclofenac	PO	50mg	tds PRN	Ceased
Ibuprofen	PO	400mg	tds PRN	Ceased
Pantoprazole	PO	40mg	mane	No change
Paracetamol	PO	1g	qid PRN	No change

Pharmacist interventions, case progress and outcomes

Day 1

- The patient was unable to communicate with the ward pharmacist.
- Prescription medications were confirmed using dispensing history after talking with the patient's son and GP.
- A Serbian translator was booked through the National Translating and Interpreting Service.

Day 2

- The patient was hypotensive with her usual prescribed antihypertensives. As a result her amlodipine was continued, hydrochlorothiazide was ceased, valsartan was withheld and the metoprolol dose was decreased.
- Patient's own medications were brought into the hospital and using the translator, a medication history was taken.
- While taking the medication history, the pharmacist discussed compliance. As a result of poor compliance a plan was established to commence a webster pack on discharge.
- Medications were rationalised with the medical team.
- The patient was counselled via the interpreter to avoid all anti-inflammatory medications due to the increased risk of kidney injury, bleeding and hypertension.
- The patient gave permission to discard ceased medications including diclofenac, ibuprofen and both strengths of aspirin.
- The patient informed the translator that her GP is unable to communicate with her if her family is not present. The translator offered their services for the patient's GP appointments.

Day 4

- A webster pack was organised for discharge.
- The medical team formal requested a Serbian translator be used for all GP appointments in their discharge summary.
- See table 1 for the complete list of medication changes from admission to discharge.

> **"Without an understanding of the plan, there is no plan."**

References:

1. Ajdukovic M, Crook M, Angley C, Stupans I, Soulsby N, Doecke C, Anderson B, Angley M. Pharmacist elicited medication histories in the Emergency Department: Identifying patient groups at risk of medication misadventure. Pharmacy Practice 2007;5(4):162-168.
2. Roughhead L, Semple S, Rosenfeld E, *Literature Review: Medication Safety in Australia*. Sydney. ACSQHC, 2013.

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