The Role of the Pharmacist Prescriber in the Acute Medicine Setting

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8th October 2010
What is Independent Prescribing (IP)?

Prescribing by a practitioner (e.g. doctor, pharmacist, nurse) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

(Improving patients’ access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England Department of Health, April 2006)
The Health and Social Care Act 2001 enabled the Government to extend prescribing responsibilities to other healthcare professionals.

The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 introduced pharmacist IP

Primary aims of legislation were:
- Improving patient access to medications
- Improving patient care without compromising safety
- Better use of healthcare professional skills
- Contribution to flexible team working in the NHS
Qualification as an IP

- Start prescribing
- Personal Indemnity Insurance
- Updating Job Description
- Registration with GPhC
- Designated Medical Practitioner (DMP)
- Exams & Portfolio
- At least 2 years post-qualification experience
- 3-6 months approved training at college/university
Scope of Practice

• Patients under Acute Medical Team

• Medicines Reconciliation

• Drug dose/choice adjustments according to changes in renal/hepatic function/other patient parameters such as weight

• Drug dose/choice adjustments due to interactions

• Doses of aminoglycoside and glycopeptides will be adjusted in line with Trust protocols if necessary based on laboratory results

• Facilitating discharge
Scope of Practice

- Initiating and changing medication and doses as a member of the Post-Take Ward Round multidisciplinary team

- Acute management of infective and non-infective exacerbations of COPD including nebulisers, steroids, antibiotics if appropriate and aminophylline

- Initiation/cessation of prophylactic enoxaparin as per Trust policy/DH recommendations

- Optimisation of statin therapy based on NICE and Trust guidance

- Nicotine Replacement Therapy (NRT)
• Support from Chief Pharmacist – clear strategy and vision
• Agreement with clinical leads
• Engagement with clinicians
• Make yourself known – a stamp!
• Audit/Research
Initial Service Evaluation

• New service hence evaluation

• Current published literature focuses on supplementary prescribing with very little focus on clinical outcomes

• There is little published research about pharmacist IP, particularly in secondary care
Aims & Objectives

• Aims
  – To develop a model of IP for the acute medical unit
  – To evaluate its impact on patient care

• Objectives
  – To implement Pharmacist IP on the acute medical unit
  – To document the numbers and types of prescribing decisions made by the pharmacist
  – To explore the clinical significance of these prescribing decisions
Methods

• **Study population, inclusion criteria and duration**
  – All patients admitted to two acute medical wards (B1 and B2; total of 28 beds) on the 40 days during which IP pharmacist cover lead to the writing of one or more prescriptions **within 24 hours of admission**.

• **Data collected**
  – Patient identifier, date and reason for admission, details of any prescriptions written plus reasons for prescribing, and whether or not each prescription was queried by the medical team by the time of the next post-take ward round (PTWR)

• If no amendments were made by the medical team, this was taken to mean that the prescription was accepted and that the IP pharmacist had not made any prescribing errors.
Methods

IP Pharmacist assessment of patient followed by writing of the prescription chart

Data entered into electronic database

Two senior pharmacists and two medical consultants assessed each prescribing decision on a scale of 0-10*

Mean score calculated and used as an index of clinical significance

No Clinical Significance

Failure to prescribe could have resulted in death

*Dean B and Barber D. A validated, reliable method of scoring the severity of medication errors. Am J Health-Syst Pharm 1999; 56: 57-62
Results

• A total of 217 prescriptions were written during the 40 days (mean 5.4 per day) of the study.

• All were accepted by the medical team without amendment or query, and the prescribing error rate therefore assumed to be zero.
Results

• The 217 prescriptions were then screened for clinical significance

• The mean clinical significance score was 4.6

• Of the 217 prescriptions, 99.5% (n=216) were of moderate significance and 0.5% (n=1) was of minor significance. None were of major significance
Current Literature Concerns

• Lack of clear strategy at organisational level and lack of funding seems

• Lack of access to medical records, accountability and compromising patient safety by not separating prescribing and dispensing

• Not having enough knowledge of patient before prescribing, physicians losing opportunity to review drug treatment, writing discharge prescriptions, effective communication with other healthcare professionals and pharmacists having time to do this (overstretched pharmacy department) and legal and professional accountability

• Inadequate clinical examination skills and diagnosis

• Potential loss of prescribing skills for junior doctors
Stakeholder Views of Pharmacist Independent Prescribers (STAVOPIP) 2010
All participants who commented on this issue did not see the purpose of a second check, suggesting that this should not be a hindrance. Interestingly, nurses commented that a second check should be part of their role, whoever the prescriber was.

I think we are really about professional competence and if you are correct then why have a check? Why do you need a check? And we can certainly see that things get prescribed, labelled, dispensed, checked, double checked and they're still wrong so it's a human factor really. I don't think you should write something that says that you have to do that or there has to be segregation but I think you do have to allow individuals to ask for a second check when they want a second check, or they want someone else to dispense it because in fact it was quite complex. It's then around the individual recognising the scenario where they have been challenged and are uncomfortable if they complete the process. I don't really think that's any different to the situation where you have a pharmacist who has screened a discharge, they may well have added drugs even if the doctor has signed it off and even if they've discussed it with the doctor, they may then label it and dispense it without a second check. I think we're getting ourselves a bit hung up on something that's not necessary.

Senior Pharmacy Manager

……do I think there is a problem with the pharmacist prescribing it and the same pharmacist screening it, that’s counter-productive I would say, what’s the point in that? Would I have a problem with a nurse giving a medication that’s been prescribed by a pharmacist but hasn’t been screened? No I wouldn’t. I would probably feel more confident giving medication from independent pharmacist prescribers than a junior doctor.

Senior Manager

……I think the focus is on the words independently prescribe, then that second check is just a hindrance as opposed to something quite positive. I don't think a second check is required.

Senior Pharmacist
Not enough clinical knowledge

• So what?
• Specialist/diagnostic skill courses available
• Working in hospital hence support available from medical prescribers
• Effective communication
• Knowing limitations

I think the main one is the lack of medical training and the fact that pharmacists don't have a medical degree, which means their understanding of disease processes and human physiology will obviously be less than that of doctors. Therefore there may be things which are overlooked or not fully understood. I think that's the main reason. I think the main issue with independent prescribing is that of safety and having not had the training that doctors have had. I think that is the most important aspect of independent prescribing that needs to be considered.

As long as everybody knows where they stand, it’s fine.

You see my personal view is that the good pharmacists will always speak to the clinicians and it just takes an informal chat and it’s much better to actually speak directly if there are any doubts. The good ones will do that and clear up confusion.

- Senior House Officer

- Registrar

- Independent Prescriber
Who does ‘normal’ job?

- It was recognised that pharmacists taking on new roles would mean that somebody else has to commit to the roles that pharmacists were traditionally carrying out.

- Incorporate as part of normal ward pharmacy.

- Business cases

- Research

It is protracting away from traditionally what pharmacists are doing, and consequently you will be doing more of that so who is doing the other work that you were doing beforehand?

Their basic role of dispensing and other things could be done by support workers, it doesn’t necessarily need to be done by pharmacists. Even talking to GPs and getting a list of drugs, you don’t need to be a pharmacist to get a list of drugs. Maybe looking into clinical support work, or pharmacist support work – Consultant.
Professional Rivalry Issues

• A key finding in previous research
• Not seen in this study
• Pharmacy and pharmacists well regarded; role recognised and accepted

Based on my limited experience I personally don’t think it would create any professional rivalry. If I was a junior doctor I would actually view it as somebody who enhances my work on the ward. It’s a two way learning process as a junior doctor, learning from somebody with the pharmacy related knowledge, and maybe even the other way around as well, because the DMP needs to learn a little bit more about clinical context. I think it would be more complementary than rivalry. - Consultant
• Pharmacist prescribing causing de-skilling of junior doctors is a concept already cited in the literature.

Most participants acknowledged this but also put patient safety ahead of anything else.

Yes theoretically, but there is always going to be a learning curve with prescribing. Every doctor will have to mature and complete their training, but you could argue that ultimately patient safety is important as well. I can admit that I have made a couple of mistakes, nothing that ended in anything detrimental but occasionally those things can be serious. Ultimately patient care must come first and it’s not that there is going to be complete lack of exposure to prescribing. As a doctor you are required to look at the drug chart every day and inquire as to whether you should change their medication, so there is plenty of scope for that. I think in this context that its permissible limitation of it, but ultimately it will be best for patient safety – Registrar.
Conclusions

• Successful implementation of Pharmacist IP on an acute medical unit

• The high number of items prescribed each day suggests a demand and key role for a pharmacist IP

• Mean severity score of 4.6 (in local study) - prescribing interventions were likely to be significant in relation to patient care

• Sustainable service - part of the existing ward-based pharmacy team

• There are issues around implementation

• Also, many solutions to the implementation issues

• Go and prescribe!!!
The Future

- Exploring error rates of NMPs vs. Medical Prescribers
- Referral service
- Increase number of IP’s in Trust
- Further research and publications

Idea is to *complement* role of junior doctors in order to improve patient safety and experience
Questions are guaranteed in life; Answers aren't.