

Pharmaceutical care: cultural, practice and professional perspectives

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Introduction The philosophy of pharmaceutical care first set out by Hepler and Strand in 1989¹ has been given new emphasis in the United Kingdom. The Government is committed to raising the quality of service in the National Health Service and to reducing variations in delivery.²

The need to make the most of the skills of the entire pharmacy workforce has been emphasised and this is very much in line with the profession's aspirations.^{3,4} Current NHS and professional strategies therefore provide an excellent platform for development of pharmaceutical care.

Although the principle of pharmaceutical care is widely accepted in the UK and the literature is growing, no defined model exists. Pharmaceutical care is poorly developed in many hospitals, hence standards of care varies enormously between patients.

Any attempt to develop services to deliver pharmaceutical care within a trust will require some degree of change and is therefore likely to encounter some opposition.⁵ This abstract describes a stage in a change management project, which sought to identify those factors, which could either enhance or inhibit implementation of a structured pharmaceutical care model in a trust.

Method Focus groups and in-depth interviews were used to seek the views of professionals within the trust on the implementation of a proposed pharmaceutical care model. This approach provides opportunities for informants to discuss priorities, opinions and ideas. Purposive sampling was used to obtain the views of staff in key positions who would be influential in the successful implementation of the model.

Focus groups were conducted with pharmacy staff to explore: perceptions of current practice, views on the proposed model and perceived barriers, feelings about extending roles, training and support needs and skill mix. In-depth interviews were conducted with various grades of nursing staff and doctors.

The interviews and focus groups were tape-recorded and transcribed. Data are being analysed with NUD*IST software, using a grounded theory approach.

Results Twelve in-depth interviews were conducted; the interviewees were four

FOCAL POINTS

- * Current NHS and professional strategies provide an excellent platform for developing pharmaceutical care
- * Focus groups and interviews were used to seek the views of health care professionals on a proposed pharmaceutical care model for an NHS trust
- * Support was found among all grades of doctors, nurses and pharmacy staff for implementing a structured model for the delivery of pharmaceutical care
- * The main barrier to wholesale implementation was perceived to be a lack of resources. Cultural barriers also existed

consultants, two registrars, two senior house officers, three house officers and two nurses. Eighteen pharmacy staff participated in four focus groups. Data analysis is ongoing, but themes are emerging.

Concerns were raised about the existing quality of patient care, in particular inaccurate drug histories, drug errors and lack of information given to patients about their medicines. Junior doctors and nurses have expressed concerns about their knowledge of therapeutics and feel they would benefit from in-house training provided by pharmacy staff.

All participants were enthusiastic about the proposed model of pharmaceutical care, which was felt would minimise risk, enhance patient care, prevent bed blocking, and save time. Pharmacy staff felt their job satisfaction would be enhanced in seeing they were actually making a difference for patients. However, they expressed fears of negative attitudes of medical staff, anxiety over personal ability, training and mentoring, and deskilling with respect to core pharmacy activities. Medical staff were concerned about continuity of service, and clear definition of pharmacy staffs' responsibilities. Initial introduction of the service was felt to be important, with regular feedback and communication.

Discussion Within the study trust there is support among all grades of doctors, nurses and pharmacy staff for implementing a structured model to enable pharmaceutical care to be delivered. The main barrier to wholesale implementation is perceived to be a lack of resources. However, cultural barriers do also exist.

For various reasons pharmacy staff

themselves may be reluctant to take on new extended roles and move on from a traditional supply service. Empowerment of pharmacy staff by training and continual support is therefore essential for any kind of successful service development.

Diplomacy will be required in the introduction and implementation of any proposed service development to ensure medical and nursing staff do not feel overtly threatened by any change. All new responsibilities of pharmacy staff must be clear, contributory and complementary.

This study has identified some of the key stakeholder concerns associated with the introduction of a structured pharmaceutical care model, and can be used to facilitate successful development of services.

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