

Just look at the benefits supplementary prescribing could bring to older people

Nina Barnett, pharmacy adviser for older people at London, Eastern and South East Specialist pharmacy services, explains why pharmacists working with older people are ideally placed to take up supplementary prescribing to improve services for older people

I am training to become a supplementary prescriber and among many lessons I am learning, the key one is about developing the right approach to prescribing.

I have reflected on what may be the differences between the pharmacist's typical role and that of a supplementary prescriber. My conclusion is that the distinguishing difference is the change from prescription monitoring to patient monitoring. Let me illustrate this point with an example. Pharmacists will be familiar with prescriptions for digoxin used for the control of atrial fibrillation (AF). Assessment of a prescription for digoxin can take many forms, depending on the needs of the patient, location of the consultation and availability of information. One may ask patients if they have had digoxin before and for how long, if they are experiencing any problems, whether they are taking any other medicines, being vigilant for the possibility of drug-drug and drug-patient interactions.

In hospital practice, one may decide to estimate a drug level, checking the indication, and if there are suspicions of toxicity or lack of effect, request a blood level, giving appropriate instructions regarding sampling times. Any or all of the above constitutes pharmaceutical monitoring for digoxin.

So what is different for the supplementary prescribing pharmacist? The clinical scenario may be similar. If the clinical management plan (CMP) states that digoxin is to be prescribed for treatment of AF, what does the pharmacist supplementary prescriber have to monitor? In addition to the above, it is an assessment of the therapeutic response to ensure the prescription is still appropriate that distinguishes routine monitoring from that undertaken by a pharmacist prescriber.

I expect that most of us do not monitor a patient's radial pulse, although we may look at the rate recorded by other health care workers. We are unlikely to listen to the apical rate. Many of us may not know what AF feels like (in a pulse) and would not be confident to read AF from an electrocardiograph.

The question is, what additional monitoring must we do to prescribe safely? As prescribers, we are bound to confirm the current clinical condition of the patient, before we represcribe. The line between

monitoring and diagnostic skills depends on the agreement between the supplementary and independent prescriber, which in turn will depend on the nature of the relationship between the two prescribers. What we must do is to confirm that the condition we are treating still requires the treatment we offer.

Since the publication of the National Service Framework for Older People in 2001, pharmacists have received multidisciplinary recognition for their role in the management of medicines for older people.

Medication review by pharmacists is now an established service within many GP practices and could, I believe be further strengthened through supplementary prescribing. The role of supplementary prescribers for older people will vary according to the level of access by patients to nursing and pharmacy services. Patients attending GP practices, community pharmacies and those living in nursing or residential homes could all benefit from supplementary prescribing.

Medication review clinics in GP practices already exist and are certainly an excellent place for supplementary prescribing to take place. GPs may refer patients directly to the pharmacist, patients may self-refer or pharmacists may select patients from their records and offer an opportunity for medication review. Nurse-led clinics based in GP practices for asthma and diabetes are good models for pharmacists to use to develop new clinics or change their existing clinics.

The community pharmacy setting is ideal for piloting the viability of shared patient records and supplementary prescribing. LPS pilot schemes for medication review may lead to supplementary prescribing partnerships, based in community pharmacies with suitable premises.

Most care homes do not link with a single GP, but the ones that do are likely to be among the first to benefit from supplementary prescribing. Once the benefits of a CMP-based system have been demonstrated, other homes with a number of GPs should be able to implement supplementary prescribing. The success of these schemes will depend on reliable, rapid access to shared patient records (ideally electronic), regularly reviewed CMPs and effective com-

munication between independent and supplementary prescribers and other members of the health and social care team.

So what have I been doing? I have been working on areas for CMPs with my medical mentor in order to institute supplementary prescribing in a 30-bed nursing home. We intend to produce web-based outlines for each disease process that we commonly see in our patients. These outlines will be downloaded and individualised to create a patient-specific CMP. Web technology is critical to us, as we intend to use available guidelines to support prescribing and these can be accessed by web links. It is clear to us that the supplementary prescribing course is just the start of the journey. The list of disease areas for inclusion in our CMPs will take us about two years to complete.

What about the hospital sector? The hospital outpatient department already accommodates many examples of pharmacist-led clinics, including preoperative, anticoagulation, lithium- and clozapine-monitoring clinics, and these are all being explored as supplementary prescribing opportunities. Many of the patients seen will be older, but there are few pharmacist clinics dedicated to the older person. This is an area that should be explored, because there may be clear opportunities for patients who regularly attend care of older people clinics (or specific disease-related clinics) to benefit from supplementary prescribing. Hospital wards may be a more problematic for supplementary prescribing owing to the rapid patient turnover, but rehabilitation or intermediate care settings could adopt the nursing home model, in which CMP outlines are available to efficiently produce individualised CMPs.

As with all new roles, supplementary prescribing is likely to be seen a challenge to the traditional practices of other disciplines. We must be confident in what we can do and firm about that which we cannot do. Our role will develop, and the scope of practice of each supplementary prescriber may increase as skills and confidence increase. We must remember that this is individual to the prescriber, and ensure our colleagues do not view supplementary prescribing as a generic function.

We also have a lot of explaining to do. Patients, carers and health professionals alike are not aware of supplementary prescribing and we will have to be ambassadors for the role until it becomes understood. But I am confident that supplementary prescribing will promote pharmacists as champions of medicines management for older people.

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