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Independent pharmacist prescribing as a natural extension to hospital practice

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The Department of Health guidance on independent nurse and pharmacist paper has been published. "Improving patients' access to medicines: a guide to implementing nurse and pharmacist independent prescribing within the NHS in England" describes the training and practice expected of an independent prescriber. It also suggests that, in the early days as a prescriber, an individual may find supplementary prescribing a useful vehicle to gain experience with this practice. We thought it might be helpful to discuss the differences between supplementary prescribing and independent prescribing and what kind of conversion we envisage might be required.

Supplementary prescribing limitations

The first think to be noted is that supplementary prescribing is not always useful. Any conversion to independent prescribing must be associated with a workforce and service redesign concept that adds value to patient care. A challenge sometimes encountered in practice as a supplementary prescriber is the need to obtain patient agreement to the clinical management plan. Also supplementary prescribing is designed for continuing care programmes and is not efficient for prescribing one-off items.

How would the service change if delivered by a pharmacist prescribing independently? Currently clinical pharmacists who cover parenteral nutrition prescribing write out the formulation and the doctors sign the forms. Other than ensuring legal compliance, this latter step in the process adds no significant value. This is why supplementary prescribing has been used. With independent prescribing there will be no requirement for a CMP so prescribing of stat doses will be more easily and efficiently achieved. Independent prescribing will also be advantageous in situations of continuing care where no CMP has yet been prepared.

In addition where patients have difficulty swallowing preparations the prescription could be easily and quickly changed by a qualified independent prescriber to a soluble, dispersible or liquid product, even where this involves changing the drug. These actions currently require a signature from a doctor, usually achieved without question but which act as a delay in the process. Facilitating this therapeutic substitution would enable pharmacy supplies of suitable products to be made more efficiently and ensure rapid patient treatment. Significantly this could avoid the need for insertion of nasogastric tubes, including where this has required the input of an endoscopist. It could also avoid the need for replacement of blocked tubes where inappropriate formulations have been used because timely changes have not been made

Pharmacists who work on admissions wards will be able to contribute significantly to patient care by prescribing relevant changes and additions made on admission and later confirmed at post-take ward rounds. An audit of prescribing practices in the hospital would reveal other examples where pharmacists could use their knowledge and expertise to prescribe safely and effectively.

Independent prescribing is an acceptable part of the pharmacist's role. Our experience has been that senior medical consultants approve of pharmacist prescribing, where a working relationship has existed. Independent prescribing as part of a clinical team will be no less supervised, however it opens up new areas to be managed more efficiently.

Clinical assessment training

Within a clinical team the pharmacist obtains information from the nurses and doctors and uses this to make prescribing decisions. Where the treatment requires ongoing clinical assessment prescribing is likely to continue with junior doctors. Pharmacists could contribute to prescribing where monitoring of patient response to treatment is via biochemical tests.

There are many pharmacokinetics scenarios where the skills of the pharmacists can be best used in managing patient care. It is however vital that communication with the medical team is maintained by adequate documentation in the medical notes and contributing to discussions during consultant ward rounds.

Recent evidence has shown the importance of blood sugar management in intensive therapy units and post-myocardial infarction. This has been incorporated into care bundles in ITU and contributes to the 10 high-impact changes recommended by the modernisation agency. Pharmacists have a role to play in ensuring that patient care does not deteriorate through acts of omission. A prescribing pharmacist could facilitate all of this prophylactic treatment. In secondary care clinical pharmacists are wholly integrated into the clinical team and access to their skills would protect patients and deliver efficient care where doctors are in training or distracted by urgent calls. There are many circumstances where bowel medicines or prokinetics are required to maintain best patient care. There is then the large area of anticoagulant management and avoidance of errors. It is not hard to see how independent pharmacist prescribing would make a significant contribution to patient care.

Knowledge and skills

The additional knowledge and skills required for independent prescribing may depend on the individual's area of practice, experience and competence. Each supplementary prescribing pharmacist could discuss with their manager and their lead clinician, what training he or she needs to become an independent prescriber. Many existing supplementary prescribing pharmacists already take drug histories or clarify what has already been documented and may need no further training. Some clinical pharmacists will use the expertise of the multidisciplinary team to support their clinical examination of patients. For example, a pharmacist prescriber on an ITU would not be expected to perform a rectal examination, however he or she would ask the nurse if the patient was constipated and prescribe laxatives if appropriate.

Assessment

Discussion with senior medical consultants reveals that where they have worked with an individual clinical pharmacist for a short time, they are happy to authorise a pharmacist in their team to prescribe independently. Once the training needs for conversion have been identified, the acquisition or confirmation of these additional competencies could be assessed in the workplace by the preparation of a portfolio of practice and by workplace observation. In addition statements of scope of practice could be updated at annual performance reviews to ensure the employer is aware that practitioners are working within their areas of expertise and can demonstrate competence. The overall responsibility for this assessment may be most suitably achieved in many cases by the equivalent of the original designated medical practitioner.

Conclusion

In summary, independent prescribing by pharmacists seems a natural extension of the role that has already been established by many supplementary prescribers. It improves patients' access to medicines, it is designed to be used by practitioners within their individual scope of knowledge and experience and, as such, it is a development that is expected to bring many benefits to patients.