

Opportunities in primary care: diary of a pharmacist supplementary prescriber

Graham Lavender, a supplementary prescriber at Southampton City Primary Care Trust, has developed the clinical examination skills necessary to monitor and start medication. He describes a typical afternoon

Qualifying as a supplementary prescriber this summer has added a new dimension to my work in general practice. A primary care support pharmacist has a number of roles within a GP practice, which include medication reviews, audit work and general support and advice on pharmaceutical issues.

As a supplementary prescriber my medication reviews have taken on a new dimension. Previously my role has been to review with the patient their individual medicines, compliance issues and concerns, and elicit any problems such as side effects. Any changes to medicines, whether stopping or starting, would normally have been initiated by referring the patient to the appropriate doctor, a relatively time consuming process not only for the doctor but for the patient as well. Now, with the advantage of clinical management plans, agreed with the independent prescriber, I can tackle many of the issues without further referral, thus optimising the practice's resources and skills.

A further dimension has been added, partly as a result of the prescribing course at Portsmouth University, but also due to my mentor GP and other doctors and nurses within the practice. They have supported and encouraged me to learn and develop the clinical examination skills necessary to monitor existing medication and instigate new medication. By outlining an afternoon of my work I hope to identify the opportunities that are open to pharmacists in primary care.

I see patients throughout the day, with half an hour allocated per appointment. In the afternoon I have slots from 2pm to my last appointment at 4.30pm, which still leaves time for any audit work. Patients are given appointments in one of five ways:

- One of the clerical staff books in patients identified from my current audit. I also conduct ischaemic heart disease and chronic obstructive pulmonary disease reviews and the clerical staff member will ensure that all patients on the register are seen by me at least once a year.
- The doctors will book in patients, often from their own surgery, when they believe my expertise may assist them.
- Reception staff will book in patients who they identify as needing review, often when they are confused about their medication.
- The practice nurse will also book patients in that have a need for pharmaceutical input — often this involves a review of the medication of new patients to the practice.

■ Lastly, after several years as a primary care support pharmacist, I have a number of patients who insist on seeing me, often because I have helped them in the past. Sometimes it is difficult to explain to them that they are asking for help outside my area of expertise.

Here is an account of a fairly typical afternoon.

2pm

The first patient is due. After being forewarned by one of the doctors, I check the patient's notes. This patient is addicted to Diconal and has also had several warnings from his last practice for threatening staff. He has been seen once at the present practice and was refused Diconal but was given Fentanyl, which he returned. As a final option the GP has booked the patient in to see me. Trying to remember my training — emphasise what I can offer the patient, avoid negatives and what I cannot do, stress that we need to work together to resolve his treatment dilemma and, most importantly, keep my finger close to the panic button — I walk round to reception to call the patient in.

The patient is a 40-year-old male and well built. I ask him to identify his main concerns with his treatment. A fairly rambling discourse follows in which Diconal crops up at regular intervals and he tells me how it is the only drug to keep his pain in check. I am reluctant to discuss the pain in great detail, partly because I have read the numerous comments and referrals he has had and partly because I suspect he is unlikely to be objective. I am particularly aware that a number of doctors have noted he has no clear symptoms of pain when examined and that a psychiatrist has suggested he is suffering from post-traumatic stress disorder from recent army days.

Keeping positive, I advise that an urgent referral to our excellent local pain clinic would be my preferred option. This is not well received by the patient. I then suggest



Mr Lavender in consultation with a patient

using baclofen for the muscle spasms he describes, but he interrupts to say it does not work. Moving on, I suggest we start gabapentin for the neuropathic symptoms he describes. He goes quiet because he does not appear to have heard of that one but, after a short silence, he dismisses it. I go on to suggest a combination of non-steroidal anti-inflammatory drugs and analgesics but again the patient says they will not work. By this time we have explored and rejected a number of options and I am aware that time is moving on. Although I have a clinical management plan for pain, and the doctor had agreed before the consultation that it is appropriate for this patient, I cannot prescribe Controlled Drugs and my brief has been to pursue an appropriate treatment option with the exclusion of Diconal. I offer the pain clinic again and to start immediately on a range of muscle relaxants, NSAIDs and analgesics. He is unhappy and threatens to report me if he is not given Diconal and it is clear little more progress will be made. I conclude by suggesting he thinks about the options the practice is prepared to offer and he leaves unhappy.

The patient left the practice the next day. Staff and doctor were delighted but I cannot help feeling I have failed somehow.

2.30pm

The next appointment is a visit to a nursing home. We only have one patient there who, from the records, has had no surgery visit for nine months. I have not been to this home before so my plan is first to talk with the matron. The patient is an elderly woman who had a stroke 11 months ago and remains on the same medication on which she was discharged: Enlive, multivitamin capsules, citalopram 40mg, flupenthixol twice a day, furosemide

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40mg and baclofen 50mg a day. The main issues are identified as increased muscle spasm from stroke, loss of weight in hospital, oedema and a lack of interest in her surroundings. We visit the patient in her room and, although she answers questions, she has little interest in what is happening. A quick examination finds no oedema but a fairly dry mouth, reduced skin turgor and a clear chest. An old leg ulcer has now healed nicely. The patient has regained the weight she lost in hospital and a quick calculation suggests a BMI of around 23. She has a regular pulse and lowish blood pressure.

The matron and I retire to discuss the options and my mind goes back to the advice one of the doctors at the practice gave me when I first started visiting nursing homes: "If the quality of life is poor it is reasonable to take a calculated risk with the medication to investigate the possibility of improving the quality of life." Sound advice and the matron herself suggests we may be overmedicating the patient. Although I have no clinical management plan for this patient, and cannot therefore prescribe, I had a quick word with the patient's doctor that morning about the likely issues that would need tackling. The matron and I agree a phased monitored reduction of drugs with the objective of getting the patient to show interest in her surroundings and getting out of bed, possibly in a wheelchair. We agree to cut the baclofen to 30mg a day from the current 50mg in a slow reduction over four weeks. We agree to discuss progress on the telephone at that point but then to follow by reducing furosemide to 20mg and monitoring for symptoms, which matron is happy to do. Since the patient has regained weight and is eating a small but balanced diet with fruit we stop Enlive and agree matron will weigh the patient monthly and telephone the results to the practice. We also agree to cut citalopram to 20mg. The matron seems delighted we have agreed a plan and she will undertake a degree of monitoring.

I make a mental note to ensure I visit at least six-monthly and if there is no improvement after the current medication change I will ask for a case conference with her GP for a review of further options.

3.30pm

I am back at the surgery and the next patient is a 45-year-old man for a routine asthma review. I take a pharmaceutical history as a first step; the patient is having fairly regular repeats of indometacin in addition to beclometasone 250µg, which was last ordered six months ago together with salbutamol. The patient explains that he has little problem with asthma and none of the characteristic symptoms but that he does complain of extreme fatigue and is thinking of having a BUPA check up. Although one of the commonest complaints from patients is lack of energy, the patient is pale and an examination of mucous membranes suggests a possible anaemia. We quickly identify that indometacin, started for gout some years ago, has been used for back pain since. We agree to stop the indometacin

immediately and I explain as gently as possible that I am concerned that there may be gastrointestinal problems from the drug even though he is asymptomatic. Writing out a pathology form for a full blood count, urea and electrolytes and a thyroid function test, I book him in for blood tests the next morning together with an appointment for his doctor the day after when the results should be back. We agree he will continue on paracetamol for the next couple of days. Since he has had no asthma symptoms and rarely uses beclometasone 250µg he accepts my offer of a prescription for beclometasone 100µg as a prelude to a further review in three months when, if symptoms are still in remission, we may try to stop inhaled steroids completely. I make a note in my diary at the end of consultation to check that the patient keeps his appointment with his GP; I will check next time I am in since there is a possibility of a GI bleed and it is not always clear if a patient has grasped the potential seriousness of a situation. Sometimes the line between frightening patients and requesting they see the GP is a fine one.

4pm

My next patient is a 58-year-old woman being treated for hyperlipidaemia and hypertension. She is on an unusual combination of drugs and it seems all alternatives have either not worked or caused side effects. She is now on enalapril 40mg, moxonidine 200µg and atorvastatin 40mg. Her cholesterol remains stubbornly at 6.5mmol/L and her last BP was still 184/94mmHg. The patient has been asked to see me by one of the doctors since they are running out of options. I always try to look at things that doctors usually skip with such patients and, while I take a pharmaceutical history, I notice from the computer that the number of repeats over the past year is not sufficient for full compliance. This is often a tricky situation. Discussing her recent long holiday, she admits to having forgotten to take her tablets with her and we go on to identify regular poor compliance as her main problem. We spend most of the appointment discussing the patient's fears and she admits that her mother died of a stroke and she really does not want this to happen to her. We decide to start completely from scratch since she has taken nothing for three weeks and we plan monthly appointments starting after a blood test for urea and electrolytes and lipids. I feel sure we will not need anything like 40mg of atorvastatin or need such exotic drugs as moxonidine now we have identified the problem. One of the advantages of a half hour appointment is that you can fully explore the problem and not, as has happened with this patient, fail to answer her fears and end up on increasingly powerful medication with poor compliance.

This patient ended up on simvastatin 20mg and a calcium channel blocker with complete control on just the two drugs. A clinical management plan was used, which allowed me to write the prescriptions at the follow-up appointment.

4.30pm

My last patient is a four-year-old asthmatic boy. His mother gives a detailed history: two weeks ago he had shortness of breath, saw a doctor at the surgery and was started on amoxicillin. Six days later he had symptoms of an acute asthma attack with severe shortness of breath, he was unable to talk, had raised respiratory rate and saw a doctor at the local walk-in centre who started oral prednisolone. All symptoms have now resolved and she is seeing me for review of his asthma management. There is no night waking and no daytime symptoms. He is on his last dose of prednisolone today. I am always ultra-cautious with children and so carry out a full clinical review; his respiratory rate and heart rate are normal. Although he is too young for peak flow I like to try anyway since it can be helpful with some young children who master the technique; again, a normal result. I listen to his chest and discover a significant expiratory wheeze on the right lower lobe. I complete the examination and percuss, but the only finding is a wheeze in one area of the lung. After five days of prednisolone I am surprised that there is still a noted wheeze. I know the doctor in the next room will have finished surgery and will be doing paperwork and, since my supplementary prescribing course, we have established a routine when time permits that we review the occasional patient as a training exercise. I explain to the mother that I would like the doctor to examine the patient himself. This he does, agreeing with my findings, and asks me to suggest treatment options. I suggest we start erythromycin to hit a different spectrum of bacteria and make an appointment to see the doctor in three days, reserving the option of a chest x-ray if there is still a wheeze in the lower lobe. The GP accepts that option and reassures the mother, giving advice to contact the surgery immediately if there is any change in symptoms, especially wheeze or shortness of breath. I explain how to take antibiotics and also go through use of the steroid inhaler and spacer.

At follow up with the doctor three days later the doctor sticks his head round my door and asks if I would like to check on the patient. I am gratified to find the chest is now completely clear and all symptoms resolved.

In closing . . .

That is the end of my afternoon. Although I have not written many prescriptions, I have undertaken a significant amount of work, including examinations, which would otherwise fall to the practice doctors. By taking some of the burden of their appointment schedules I am leaving them the patients that really need the skills of a clinician. I see the role of the supplementary prescribing pharmacist as continuing to develop and, while we can take on a significant portion of the work of the doctor, in turn skilled technicians can take on some of the work of the pharmacist. This ensures everyone works to his or her full potential and that the NHS benefits from the most cost-effective use of staff.