

EUROPEAN SOCIETY OF CLINICAL PHARMACY

Practice research should be used to inform policy decisions

The 32nd European Symposium on Clinical Pharmacy took place in Valencia, Spain, from 29 October to 1 November. The theme was "Pharmacists in the health care team: standards of practice and systems of care". Sonia Sanghani reports

Health care professionals are required to have an evidence-based approach to their practice, said Moira Kinnear, Lothian NHS Trust, Scotland. There is a need to shift thinking towards evidence-based community pharmacy practice and to use pharmacy practice research in the design and delivery of pharmacy services. Although practice is usually determined by policy, which takes into consideration legislation, resources, professional ethics and individual patient needs in different countries, there is nevertheless a role for using practice research to inform policy decisions in order to develop and implement standards of patient care and standards of pharmacy practice.

CLINICAL PRACTICE GUIDELINES

"We know that decision-making is not based only on evidence; it is also based on patients, their circumstances, preferences, resources and the societal context," stated Mrs Marta Aymerich, Catalan Agency for Health Technology Assessment and Research, Barcelona, Spain. However, evidence assists decision-making at both policy and clinical levels. Evidence-based pharmacy can therefore be defined as "the process of systematic search, assessment and use of results as the basis of clinical pharmaceutical decision-making. It is the detailed, explicit and well thought out use of the best available information when making a decision about patient care in the pharmacy."

Clinical practice guidelines are systematically developed statements to assist these health care decisions. The process of developing clinical practice guidelines can be time-consuming, taking anywhere in the region of nine months to three years, depending on the complexity of the condition. Topic selection depends on criteria such as prevalence in the population and

variability in clinical practice. Once the topic has been defined and the scope of the guideline narrowed sufficiently, the development process begins. This requires input from a multidisciplinary team whose main task is to undertake a systematic review of scientific evidence. Existing clinical practice guidelines are assessed for their quality and applicability. These can be updated with the latest scientific evidence and then contextualised. Mrs Aymerich recommended the use of databases such as the National Guideline Clearing House, a United States database containing quality guidelines from all over the world. Acceptance into this database is heavily dependent on quality methodological criteria.

To compare existing guidelines, a European instrument, entitled AGREE, has been developed. Issues such as target populations, interventions, etc, can be compared with this instrument. AGREE explores domains such as scope, purpose, stakeholder involvement, rigour of development, quality, applicability and editorial independence.

In an effort to overcome publication bias, statistical methods can be used to double check the quality of published data. The Cochrane Collaboration is also proving to be a proactive player by setting up a database of all approved clinical trials. If data from these trials remain unpublished, this may indicate bias. Mrs Aymerich urged researchers to move away from thinking that negative results are not relevant and therefore should not be published. For clinical decision-making purposes, such results have a bearing on the development of quality, evidence-based practice guidelines that serve society's interest.

Once the preliminary version of the guidelines has been developed and peer-reviewed by an external review panel, a pilot study is undertaken to test feasibility and design issues. The final version has to be in a flexible, user-friendly format, for example,

paper-based, electronic versions and algorithm-based. Different recommendations are written in many different ways. The most important point to bear in mind is that all recommendations should be graded from "best evidence" to "not enough evidence" to enable the user to assess the quality of information that forms the basis of their own decision-making. This is an issue of transparency and is vital to clinical practice guideline development.

For clinical practice guidelines to be regarded as successful, there has to be development, dissemination, implementation and evaluation. Although there are issues surrounding all of these processes, the main areas of concern centre around the evaluation of the impact of guideline implementation. Mortality and morbidity changes happen over a longer time-frame than that during which the guideline is being evaluated. Other environmental effects, such as comorbidities, pharmaceutical company marketing techniques and lifestyle choices, influence the impact of the use of guidelines.

NATIONAL GUIDELINES

For many different guideline groups, the idea of national or European guidelines seems an attractive proposition. Cultural influences are visible when it comes to interpretation of evidence at levels below the "gold standard" randomised, controlled trial. A practical solution would therefore seem to be that of developing national guidelines for local and regional implementation. This would provide guideline implementers with the flexibility to take into consideration local needs, resources and available implementation strategies. There was a call for all guideline developers to network more closely with each other at local, regional, national and international levels to ensure the highest standards of patient care are delivered within their countries.

Practice research mirrors drug development stages

The framework for research into complex health services could be paralleled with the stages of drug development research (pre-study phase to post-marketing surveillance), according to Mrs Hannah Herborg, Pharmakon, Denmark.

Service developers need to undertake pre-delivery work, modelling, definitive control trials and long-term implementation. Research, pilot studies and instrument

testing are used during the service development process in order to learn as much as possible about service delivery, design and feasibility in practice.

Once services have been developed and tested, implementation provides valuable opportunities to observe activities in a "live setting".

Although RCTs are important for implementation purposes, Mrs Herborg

believed that they are essentially overvalued. She recommended the use of mixed research methodologies as RCTs are designed for technical, controllable situations and practice research into service development is more of a "moving target" — a social construction that exhibits many variables and is highly context dependent.

Project management skills and tools are essential components in understanding

the research of new service design and implementation. Testing and modelling the service, designing appropriate tools to support implementation such as decision algorithms, training manuals, guidelines, practice standards and documentation methods, form an invaluable part in shaping the service and creating the evidence base to support the pharmacist's role in delivering high quality pharmaceutical care.

BARRIERS TO IMPLEMENTATION

Barriers to implementation are not just related to time, workflow, skills, attitudes and values. There is a more fundamental issue which needs resolving; that of improving the clinical judgement competency of community pharmacists if these services are to be implemented successfully and sustainably. From Danish research, internal pharmacy training programmes have proven

more effective in improving performance in this area than complex, externally developed courses.

Quality audits and the use of "mystery shoppers" also support sustainable implementation.

In Mrs Herborg's experience, all support mechanisms, documentation processes and service designs are only implemented successfully if they are kept as simple as possible with easy to follow procedures.

Integrating pharmacists into the health care team: what is the key to success?

Professor Steve Hudson, University of Strathclyde, Scotland, emphasised that improving health gains in a population requires all agencies involved in health care delivery to undertake more collaborative working.

New ways of practising health care require pharmacists to learn about team-working and also require closer links between research and practice.

With hospital services in mind, he recommended the horizontal integration of pharmacists into the health care team to supervise the patient's journey through the secondary care system better. This enables pharmacists to verify treatment decisions and monitor and evaluate patient outcomes, resulting in a pharmacy service based on individual patient assessment and separation of clinical and dispensing tasks, with pharmacists and technicians mutually supporting each other's roles. Building such services into the hospital setting would streamline systems of discharge of patients into the community setting.

Professor Hudson highlighted two projects designed to streamline hospital integrated care processes in cancer care and outpatients care, alongside a third project based in community pharmacies in the area

of rheumatoid arthritis and medicines management of patients on methotrexate. Documentation plays an important role in the pharmaceutical care plan and the data from these projects is being systematically collected and developed into a database for evaluation purposes. Pharmacists are wary of writing down their activities and this may be due to lack of self-confidence in their decision-making abilities and fear of taking responsibility.

Professor Hudson reminded participants that the opposite of "integration" is "disintegration" and urged pharmacists to join health care colleagues in striving to reduce the impacts of disintegration within health care and society in general.

A US PERSPECTIVE

Dr Brian Isetts, University of Minnesota, US, warned that "national economies would not be prepared to bear the burden of paying pharmacists the equivalent of \$100,000 to count out tablets in fives". He provided participants with his "recipe" for the successful integration and implementation of pharmacists and pharmaceutical care services into health care team settings. The two major components (ingredients) are the

ability of the pharmacist to assume full responsibility for all the patient's drug-related needs and the separation of the care and consultation process from the dispensing process. Over-specialisation and unrealistic expectations, as well as ineffective communication and lack of relationship building and trust between health care professionals and patients, are recipes for ineffective integration. Feedback mechanisms are important since they ensure the services provided by pharmacists within the "pharmaceutical care" framework are continuously improved. Patient and employer satisfaction are big driving forces to moving pharmaceutical care from a supply-oriented to a demand-oriented service.

Dr Isetts encouraged pharmacists to take responsibility for implementing pharmaceutical care more widely. Linking with patient and consumer lobby groups will provide the momentum to become more demand-oriented. Undergraduate and postgraduate programmes have much to do to ensure that pharmacists are equipped with the appropriate caring attitudes, the ability to take responsibility for their decisions and the self-confidence and self-esteem to work in these new, challenging, demanding, yet professionally rewarding ways.

GUIDANCE FOR REPORTS ON MEETINGS AND CONFERENCES

Timing and submission *The Pharmaceutical Journal* welcomes submissions about meetings and conferences. Please contact the editorial department before sending in a report, ideally before the meeting takes place, to check that it is not already being covered and to discuss the length of the report.

Photographs are also welcome, provided they are of publishable standard.

Reports should be sent in by e-mail or on disk. If the meeting is newsworthy, the report should be sent in by the Tuesday immediately after it takes place to ensure immediate publication. All reports should be sent within two weeks of the meeting to guarantee publication within a month of the meeting. Reports submitted later than this will not always be published in full in *The Journal*. It may be necessary to publish an abbreviated version in print and post the full report on *PJ Online* (www.pjonline.com).

How to prepare a report Readers need to be encouraged to read reports, so start the report with the most interesting item, not with details of what, where and when the meeting occurred.

Concentrate throughout the report on the most newsworthy contributions to a meeting, such as valuable information that has not already been publicised or strongly worded opinions voiced by influ-

ential speakers. Reports that repeat what readers already know or cover old issues will not be interesting.

Write about what people actually said rather than what they talked about. Ask speakers for copies of their talks or notes. Do not submit reports that are just lists of speakers' topics; they are of no value to the reader. Instead of writing "Professor Plum gave a fascinating account of continuing professional development," readers will want to know exactly what Professor Plum said that was so fascinating.

Do not give every speaker an equal number of words. With the exception of keynote speakers if someone says nothing of interest, then do not report it, however well-known the person. If the keynote speaker says nothing of interest, consider how valuable a meeting report will be.

Advice for photographers *The Journal* is unlikely to publish more than two or three photographs from most meetings, so it is best to concentrate on the main speakers. The ideal time to take photographs is at the beginning of each address, while the speaker is still involved in introductions and is likely to be looking out at the audience rather than staring down into his or her notes. Take several shots of each speaker and always aim to be as close as possible to the podium, even if it means obstructing the view of the audience for a short time.