

Pharmacists should use evidence base

Integrating research, education and clinical practice was the theme of the ESCP spring symposium last week. Dawn Connelly reports

Evidence-based practice methodology has much to offer clinical pharmacy, Phil Wiffen, director of training and co-ordinating editor at The Cochrane Collaboration, told participants at the European Society of Clinical Pharmacy spring symposium in Stockholm last week.

However, he warned that if pharmacists do not keep up to date with the literature, they will not know what best evidence is. "That can be a challenge. There are now 30,000 biomedical journals . . . and those are still growing by 7 per cent per year," he said. "The reality is we cannot read all of it, and so systematic reviews can be important from that point of view."

Mr Wiffen presented a Cochrane systematic review to identify interventions that improve antibiotic prescribing for hospital patients. The review is due to be published later this year. He explained that the review holds clear lessons for both practitioners and academics.

The initial literature search yielded 743 articles, 350 of which contained original data about interventions in hospitals. Among these, 165 were uncontrolled before and after studies and 79 were inadequate interrupted time series studies. This left 107 studies for consideration. A further 39 studies were excluded because data were irrelevant or could not be interpreted or the design was inadequate.



Phil Wiffen: use a multidisciplinary approach to research studies

Most of the remaining 66 studies used interrupted time series methodology. Interventions commonly identified included expert approval of restricted drugs, general education, recommending changes to therapy, removal or restriction, and reminders.

"There were too few studies of the efficacies of individual interventions to allow reliable conclusions to be reached about the efficacy of each," he said. In addition, he explained, it was not possible to reach conclusions about the most effective interventions. He said that although pharmacists were the principal deliverers of interventions, they

used prescribing data as their only outcome measure. "That was a real shame. If they had joined up their thinking with their multidisciplinary teams, we would have had more useful data," he said.

Mr Wiffen summarised the lessons that practitioners should take from the review:

- Interventions to optimise antibiotic prescribing can improve therapy in hospital patients
- Interventions should be implemented according to local circumstances
- Multiple interventions are not better than single interventions

Lessons for academics include:

- Be aware that the ideal study requires capture of drug, microbiological and clinical outcomes, not just financial savings, and that interrupted time series methodology should be used to measure this sort of intervention
- Check if the target intervention is increasing or decreasing before the study is started
- Conduct interrupted time series studies for at least 12 months pre and post intervention, with data capture at monthly intervals
- Use a multidisciplinary approach

No career structure for teacher-practitioners

Lack of a structured career path is one of the challenges that teacher-practitioners face in the UK, according to Jennifer Silverthorne, a clinical tutor at the University of Manchester.

"There is a huge variation in the role — the teaching commitments, the grading, the salary and the employers that we have. Therefore there is no obvious career structure or progression," said Ms Silverthorne. She explained that it is not clear how teacher-practitioners will fit into the career structure for pharmacists specified in Agenda for Change. "Teaching is recognised as integral for all senior posts but it is not recognised as a specialty in its own right," she said.

However, consultant pharmacist posts, which, Ms Silverthorne explained, have recently been developed in the UK, involve a substantial amount of teaching within a senior clinical role. "This may be an avenue for teacher-practitioners to follow in the future," she proposed.

A further challenge highlighted by Ms Silverthorne is the increasing demand for clinical teaching. "Most schools of pharmacy are increasing the number of undergraduates that they recruit and new schools of pharmacy are opening every few years. This means that our teaching skills will be required for larger numbers of students," she said. "It is important that we maintain high standards of teaching."

Different challenges face teacher-practitioners from other European countries, such as Serbia, Spain, France, Sweden and Germany. Lack of funding was an issue that was raised by several speakers.

Ulrich Jaehde, University of Bonn, Germany, said: "The main obstacle is financial constraints. Who pays? It is not possible for the university to pay as it is underfunded and it is also unlikely the hospital will pay. We urgently need new financial models." The fact that teacher-practitioners are not recognised as faculty members within universities seems to contribute to the funding problems. In addition, it appears that there are not enough clinical pharmacists in these countries to support clinical teaching and hospital visits for all students.

Nurse gives self-care advice from pharmacy

Sara Claesson, a community pharmacist in Sweden, described a project in which a qualified nurse worked at her pharmacy and provided a "drop-in" counselling service on self-care issues for four days per week.

Ms Claesson explained that the aim of the project was to relieve pressure on the local health centre. A quantitative study was conducted to determine the number of visitors counselled by pharmacy staff or by the nurse during two six-week periods. During the same periods the number of telephone enquiries about self care made to the health centre was recorded.

Results showed that fewer patients were referred by pharmacy staff to the health centre and that more visitors were counselled in the pharmacy. The health centre received fewer calls about self care.

However results also showed that only 28 of 100 pharmacy visitors interviewed were aware of the service. "Increased marketing of the service is needed," Ms Claesson concluded.

The European Society of Clinical Pharmacy spring symposium took place in Stockholm, Sweden, from 26 to 28 May

Pharmacist-managed intervention project in first-time statin users

During a session on documenting and evaluating clinical pharmacy practice, Marco Oosterveld, a community pharmacist in the Netherlands, described an ongoing project in 29 pharmacies to evaluate pharmacist-managed interventions to improve compliance in first-time statin users.

Pharmacists make the first supply of statins according to a structured computerised protocol. Patients are then reviewed by the pharmacists at three, six and 12 months following the initial supply. During this review the pharmacist checks the patient's compliance, identifies any drug-

related problems and measures triglycerides, total cholesterol, high-density lipoprotein and low-density lipoprotein. "These values are used to educate and motivate patients since we believe an informed patient is more compliant," explained Mr Oosterveld. All stages of the consultation are structured by following the computerised protocol, he added.

Mr Oosterveld told participants that he has recently secured remuneration for the statin consultations and from January 2006 the pharmacists will receive €46 per patient per consultation for three consultations.



Marco Oosterveld: monitors statin users

Motivational interviewing technique trialed in Swedish pharmacies

A project that uses motivational interviewing to change lifestyle habits or behaviours, was described by Eva Vegfors, Apoteket AB, Sweden.

Apoteket AB (a limited company owned by the Swedish state) and the Centre for Public Health Science in Östergötland coordinated the project, which was initiated because the Swedish government has developed a national public health policy that identifies Apoteket as an important provider of independent health information. The general

principles of motivational interviewing are to express empathy and understanding, to weigh the benefits and drawbacks of the behavioural change, to roll with resistance, ie, do not argue, and to support capacity for change. It involves two parts: measurement of the patient's readiness to change and an interview adapted to that readiness.

Ms Vegfors explained that the concept of motivational interviewing, developed in 1991, had been adapted to pharmacy and a

manual had been produced to guide staff through the interviewing technique.

So far it has been tested on patients purchasing over-the-counter products for smoking cessation, with positive feedback from the staff involved, said Ms Vegfors. The next step is to evaluate patients' opinions of the technique to determine whether it is effective in changing behaviours. If this is successful, the method can be implemented in all pharmacies in Sweden.

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