

Give your staff a higher profile and the patients a better service

By DEBBIE ANDALO

For a hospital pharmacy in the North East of England, something had to be done when the service was performing at less than its best and destroying job

satisfaction

Patients discharged from the Queen Elizabeth Hospital in Gateshead were sent home regularly without their medication and told to come back later to pick up their dispensed drugs. This was because the pharmacy was so disorganised and slow. Frequently, patients could not be bothered to return and instead, they would telephone their GP demanding a home visit and another prescription. At the same time that the relationship with GPs was deteriorating, the pharmacy was also facing problems inside the hospital. Out of every three prescriptions written by hospital doctors, two had to be queried because the medicines on the prescription failed to match those on the patient's chart. The system was at crisis point and something had to be done.

Two years on, the hospital pharmacy is now cited by its medical directorate as one of the best reasons for working at the Queen Elizabeth. So what triggered this new vote of confidence? The hospital decided to bring in a new patient-centred pharmacy service which relies on a different skill mix between technicians and pharmacists. The result has brought greater job satisfaction, faster turn-round of prescriptions, fewer complaints, increased the status of the pharmacists and their team across the hospital and repaired the damaged relationship with GPs.

Janet Bass, pharmaceutical services manager and a pharmacist at the hospital, says: "When patients go home they now bring boxes of chocolate to the pharmacy for the



Changing the skill mix between technicians and pharmacists results in greater job satisfaction

staff before they leave. In the past, it was generally felt that it was the pharmacy which got all the complaints while the nurses got the chocolate. All that has now changed.

"The patients feel that the pharmacy department is part of the hospital service and for the first time we feel that the work coming into the dispensary is manageable. Under the old system, the dispensary would receive a third of its work after 3pm. It was totally frenetic and by the end of the afternoon we would have patients queuing up at the dispensary. In the past, patients were sent home in taxis and asked to come back for dispensed drugs — that was standard discharge procedure to get around the slow system."

The new system, which is currently being extended to cover surgical wards, was first introduced across 10 medical wards comprising 200 of the 550 beds at the hospital. Mrs Bass says: "The medical beds were the busiest in the hospital and were also responsible for half our drugs expenditure; we felt that if we could make it work in that department there would be no argument that it was not doable elsewhere."

ROLE EXTENSION

Managers decided to extend the role of pharmacy technicians who had already undergone in-service training in technician checking. These technicians were moved out of the pharmacy and on to the wards. A technician and a pharmacist work together in each of three teams and share the responsibility of the medical wards.

The technicians stay on their wards from 8.30am until 1pm when they break for lunch. After lunch, they return to the pharmacy for the remainder of the day. The pharmacists, however, remain on the wards all day.

The first job of the morning is for the technicians to check the details on the patients' drug charts with those of the drugs they are taking on admission. As part of the initiative, patients are encouraged to bring any existing medicines into hospital with them. "Under the old system no checks were made against the patient's original chart because we were in the dispensary all the time, distanced from patients," says Mrs Bass. The patients' drugs, if correct, are then locked in their own personal drugs locker next to the bed.

If necessary, the technician will then place an order with the pharmacy for any drugs which the patient needs but which have not been brought in. The technician will also send through to the pharmacy department the patient's full drug details so that discharge medication can be prepared.

Mrs Bass explains: "We work on the assumption that the patient will take home the same product as the one they were taking on admission. In some cases, you do get dose changes and we get round that by producing a new label. The intention is to prepare the patient's take-home drugs ahead of discharge."

DRUG LOCKERS

The introduction of drug lockers has fundamentally changed the make-up of the

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Panel 1: The Queen Elizabeth model

Technicians

- | Start on wards at 8.30am
- | Check patient drugs against patient chart and drug stocks
- | Order any drugs as necessary
- | Work in dispensary in afternoon

Pharmacists

- | Follow patient from admission to discharge
- | Take patient drug history on admission
- | Clinically screen discharge prescription
- | Counsel patients about medication
- | Deal with enquiries from doctors and nurses face to face

wards' drug trolleys. Nurses doing the drug round open the patient's personal locker and administer the drugs kept there. Only medication which needs to be injected, or simple medicines, such as paracetamol and lactulose, are kept on the trolley. Mrs Bass says: "It means that nurses no longer have to scabble around on the drug trolley to find the appropriate medicine. They have commented also on how tidy the trolley now is." The hospital decided against allowing patients to self-medicate, although this possibility is being considered on surgical wards. Mrs Bass explains: "We didn't really feel that self-medication was appropriate on medical wards where there is a fast turnover of patients.

"The other issue is that the patients are often acutely ill when they are admitted, and can be confused or even delirious. Self-medication was not a priority for the new system."

PHARMACISTS' NEW ROLE

The pharmacists' new role on the wards includes checking patients' drug histories when they are first admitted to the medical admissions unit. Mrs Bass says: "In the past, the drug history was the area where there were a lot of errors. There used to be quite a lot of anomalies, particularly around whether a patient needed a particular brand of drug or if they required a slow-release preparation. The doctors, who traditionally under the old system had gone through the drug history with the patient, really didn't understand these subtle differences." This new responsibility for the pharmacists has enhanced their job satisfaction and also the role they play within the hospital. Mrs Bass comments: "Under the old system, the pharmacists felt that they were only ever able to influence a small part of the process. They felt that the only thing they were in control of was the prescription once it had reached them in the department. And when the prescriptions arrived there, they discovered that two out of three of them were not dispensable because of inconsistencies between the drugs on the

prescription and the patient's chart."

Anthony Young, who is surgical directorate pharmacist at Queen Elizabeth Hospital, has the responsibility of introducing the patient-centred pharmacy system to the surgical wards.

Mr Young, who worked under the old system when he was a preregistration trainee, is positive about the reorganisation. He says: "My job satisfaction has improved quite a lot. Under the old system, I felt that I was being dictated to as the work came in and I had no control over it.

"Now I feel that I can control everything coming into the pharmacy and that I have a structured approach to the work on the wards."

He believes that his constant presence on the wards, rather than being hidden away in the dispensary, has increased the status of the pharmacy profession in the hospital, not only with patients, but also with other health professionals. Recently, he has been invited to be part of the multidisciplinary team which is responsible for amputee patients and has also been recruited to write a protocol for the treatment of constipation. He says: "These kinds of things just didn't happen before as far as pharmacy was concerned. But I feel I am now seen as part of the team, rather than as a prescribing police officer. I am in constant touch with the nurses and doctors and am involved with the patient from admission right through to discharge."

His new role also includes counselling patients about existing and new medication, screening discharge prescriptions to ensure they are clinically correct, and dealing with any drug issues on the wards. The variety of the job has meant he is happy to stay at the Queen Elizabeth. "It's definitely encouraged me to stay. I think the job I have here now is much better compared with elsewhere because I am spending 90 per cent of my time on the wards," he says.

JOB SATISFACTION

Pharmacy technician Deborah Shannon also reports greater job satisfaction since the new skill mix was introduced. The benefit for her is that she now feels she has some control over her work flow. She says: "In the past, I would have been in the pharmacy at the beginning of the day for about an hour-and-a-half before the work came in. And then, when the work did come in, it all came in at once — from all 25 wards."

She adds: "Because we are now out on the wards first thing in the morning and follow a strict timetable, the work flow is much more structured." Being on the wards also

means that she feels less isolated. "I didn't used to know anybody around the hospital because pharmacy didn't have a very high profile," she says. "Now that we are out on the wards, pharmacy staff have their own identity and can build up a rapport with other staff as well as patients. The patients benefit because they have more contact with the pharmacy team and I like it when I'm in the dispensary now because it means I can put a face to the name on the prescription. In the past, it was all a mass of names and scripts."

Introducing the new patient-centred system has also had financial benefits across the NHS. It has reduced drugs wastage because patients are leaving hospital with their medication and no longer have to consult their GP for a prescription. Mrs Bass estimates that the £53,000 bill for introducing the system has been offset by savings made on drugs because patients now continue to take the medicines they have brought with them from home rather than relying on hospital supplies. Costs are also reduced in primary care because they no longer seek a prescription from their GP when they leave and are discharged with sufficient medication for a minimum of 14 days.

The new working practices at the Queen Elizabeth are highlighted as an example of best practice in the Department of Health document "Improving working lives for the pharmacy team"¹ which was published a year ago and is aimed at helping to promote a high quality and motivated work force in the pharmacy department.

Mrs Bass says the system could be adopted by other hospital pharmacies provided the operational managers and the clinicians share the same goal and have a clear vision. She has this advice: "You must have a party line and stick to it. It's a question of saying that is what we have agreed and that is what we will deliver.

"It's very much about working as a team and not letting the leaders go off at a tangent. The system has to work for 52 weeks of the year and for all staff."

The system has definitely helped with recruiting technicians and helped with the retention of pharmacists. Patients and other health professionals can also see the benefits. But the biggest change has been how starkly it has illustrated the vital role the pharmacy team plays in a large district general hospital. Mrs Bass says: "The critical issue of care now is if we don't get to the patients then they don't get their medication. The sad thing under the old system was that if the pharmacist was off the ward for a week nobody would ever have noticed."

REFERENCES

1. Department of Health. Improving working lives for the pharmacy team. London: DoH; 2001. www.doh.gov.uk/iwl/iwlparmacy.pdf