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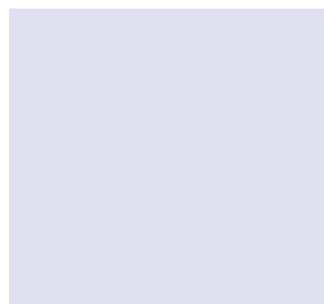
First part of renal services NSF published (... well, most of it)

Much of the first part of the National Service Framework for Renal Services was published last month. However, the guidance on medicines management, a key aspect for hospital pharmacists, is yet to be made available at the time of going to press. According to a Department of Health spokesman, it is to be published shortly.

The body of the NSF sets out five standards to be delivered by the NHS by 2014 (see panel). For each standard, markers of good practice, to be used as performance indicators, are also described. These include medicine-related markers such as the effective treatment of anaemia to minimise disease progression and complications and, in transplantation, the appropriate use of anti-rejection treatment and preventive therapy to control infections. Immunosuppressant use is to follow National Institute of Clinical Excellence guidelines, due to be issued in April.

Caroline Ashley, chair of the UK renal pharmacy group and principal pharmacist, renal services at the Royal Free Hampstead NHS Trust, London told *Hospital Pharmacist* that the NSF is focused on meeting patients' needs at a local level and provides pharmacists with opportunities to improve patient care, for example, through involvement in medication review clinics.

The first part of the renal NSF is available at **www.doh.gov.uk/nsf/renal** [See "brief" for changes to the DoH's web address]. The second part will cover the prevention of renal disease and care at the end of life.



Brad Nelson/SPL

Transplantation service standards form part of the new renal NSF

Renal standards to be delivered by 2014

Access to information Patients with chronic kidney disease are to have access to information, enabling them to make informed decisions and an agreed care plan that supports them in managing their condition
Preparation and choice Patients approaching established renal failure are to be prepared for renal replacement therapy early enough so that complications and disease progression are minimised and the choice of treatment is maximised
Access surgery Surgery to give access for dialysis is to be timely and appropriate and monitored to achieve maximum longevity
Dialysis Appropriate dialysis designed around their individual needs is to be delivered to patients throughout their lives
Transplantation Patients likely to benefit from a kidney transplant are to receive a high quality service that supports them in managing their transplant and achieving the best quality of life

Renal failure is the subject of this month's special feature (p49–61). An article about promoting adherence in renal transplant patients is at p69–71.

HPG calls for better communication

Ideas on how to communicate more effectively with its members are being sought by the committee of the Royal Pharmaceutical Society's Hospital Pharmacists' Group (HPG). The committee also wants to encourage members to become more involved in the group's work, including advising them on issues they would like to see addressed, and standing for election to the committee. Ideas should be e-mailed to **liz.griffiths@rpsgb.org**

The call is part of a promotional campaign by the HPG committee to raise awareness of the role that the groups' committee plays in helping to shape hospital pharmacy practice and influencing the wider political environment in which hospital pharmacists practice.

Activities carried out by the HPG include assisting the Society in formulating its response to the Government's Agenda for change process and developing updated guidance on the safe and secure handling of medicines ("Duthie"), which is due to be published later this year. Good practice guidelines on medicines management, which aim to reduce the risk of drug errors during patient admission and discharge from hospital, have also been produced. [See p72–73 for an article based on these guidelines].

Liz Griffiths, secretary to the HPG committee, stressed that all pharmacists working in the hospital environment are entitled to belong to the HPG and are encouraged to do so. HPG committee members are elected by the members of the HPG group. Three vacancies arise on the HPG committee each year, and group members will be invited to submit their nominations in March.

More information about the committee members and the work of the committee is available on the HPG webpage (available through the Society's website at **www.rpsgb.org**).

brief

A new-look website for the Department of Health is to be launched from February 9. The website address has also changed – to **www.dh.gov.uk**

Incompatibility between some needle-free connectors and the Luers of pre-filled syringes is the subject of a Medicines and Healthcare products Regulatory Agency safety warning, issued on 28 January. More details from www.devices.mhra.gov.uk

Star ratings do not reflect the quality of clinical care provided by hospitals, according to research published on the *BMJ* website. The authors (Rowan et al) suggest that crude mortality data are misleading because they do not take into account the fact that higher-rated trusts tend to be teaching hospitals, where patients are generally less severely ill on admission to critical care units. A copy of the paper is available from **www.bmj.com**

Amendments to the NHS (Charges to Overseas Visitors) Regulations 1989 come into effect from 1 April. Full details are available from www.doh.gov.uk/overseasvisitors/nhschargeconsult.htm

Has your department received the 2004 edition of the Medicines Compendium? A copy of the book, which contains summaries of product characteristics for UK-licensed medicines, is available free to each NHS hospital pharmacy on request to **compendium@omsg.co.uk.** One free copy is also sent automatically to medicines information officers.

Making the next generation of hospitals safer for patients is the subject of a new partnership between the NPSA and NHS estates. Further information from www.npsa.nhs.uk

Days numbered for sleeping on the job?

On-call pharmacy services may need to be reviewed following guidance from the Department of Health which states that time spent by residents asleep during their on-call shift must be classified as working time for the purposes of the European Working Time Directive (EWTD). The EWTD was enacted in the UK in 1998, and restricts the working week to 48 hours and requires a minimum rest period of 11 hours between shifts. This guidance follows a ruling last September in the European Court of Justice (ECJ) known as the "Jaeger judgement".

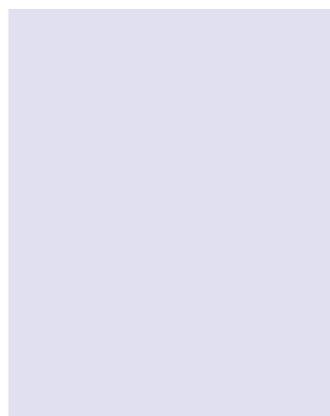
Norbert Jaeger, a resident surgeon from Germany, took his hospital authority to court claiming that his employer was breaking the EWTD. Dr Jaeger worked a regular 38.5 hour week, but was also required to spend around 30 hours a week on-call, and on the hospital premises. An on-call room with a bed was made available to Dr Jaeger, and he saw patients when requested to by hospital staff.

Dr Jaeger claimed that the time he was required to be on the hospital premises should be counted as "working time", even if he was asleep. He also claimed that he was not being given the minimum 11 hour rest periods to which he was entitled under the EWTD, as he was often required to go back to work immediately after completing a night on-call.

The ECJ ruled in favour of Dr Jaeger, saying that staff who are required to be available to provide a service must be regarded as working. The court further stated that this was not altered by the fact that the employee is provided with a bed, and allowed to be asleep.

The court also ruled that the time spent asleep during an on-call shift could not be regarded as rest time by his employers. He was therefore entitled to a minimum 11 hour period of rest, before being asked to work again.

The DoH guidance has been issued following the Jaeger case and the similar SiMAP judgement, involving a group of Spanish doctors. The DoH states that "staff who are required as part of their duties to be resident in hospital or other place of work out of hours and who are provided with on-call facilities are considered to be working during their period of duty. The whole of the resident on-call period counts as working time whether or not the member of staff is working." The DoH has said that the rules are different for staff who are not required to be at their place of work. "Staff who are off-site, non-resident on-call or who are not required to be continuously present at the hospital or other place of work are not considered to be working unless called to do so."



Time spent sleeping on-call is now classified as "working time"

Just one night on-call each week could take residents' hours over the maximum of 48 a week. However, implications of this guidance will depend on the current on-call arrangements for each hospital.

Shift working

The pharmacy department at the Southern Derbyshire Acute Hospitals Trust (comprising the Derbyshire Royal Infirmary and Derby City general hospitals) changed its on-call system a couple of years ago. The change was made in response to increasing workloads and concerns about the safety of junior pharmacists working excessive hours. Sixteen pharmacists now work on a shift system, which includes the overnight shift from 8pm to 8am. The pharmacist working overnight answers the bleep, provides information and makes supplies as was the practice with the previous residency system. However, in addition, they do other clinical pharmacy duties, eg, reviewing new patients, taking drug histories on the admission unit, etc. This then forms part of their normal working hours, and they observe the requirement for at least 11 hours rest at the end of the shift. The shift working pharmacists are supported by shift working technicians and "second on-call" experienced pharmacists.

Clive Newman, principal pharmacist for clinical services at the trust, explained that not only is the new system compliant with the law, but it also allows pharmacy to offer a true 24-hour clinical pharmacy service, without excessive hours for staff. "We believe that this shift system offers fairer hours to our pharmacists, a better service for our patients and supports recruitment and retention within the trust," he said.

Many on-call pharmacists may be happy working more than 48 hours a week but will need to sign a "waiver agreement" to comply with the law. However, the signing of a waiver agreement cannot be a requirement of being offered a job, and an employee who has signed a waiver can revoke this simply by giving appropriate notice.

The EWTD may provide opportunities for some pharmacists, such as those at Winchester's Royal Hampshire County Hospital which is one of 19 pilot sites for reduced junior doctor hours [from 1 August, junior doctors can only be required to work for 58 hours a week, with the maximum hours dropping to 48 a week in 2009]. Pharmacists in Winchester have taken on additional roles on the emergency medical assessment unit, taking over some of the work previously done by junior doctors. Between 8am and 7pm on weekdays, pharmacists record drug histories, look for possible cases of drug-induced admissions and attend the two daily consultant ward rounds. Cathy Pogson, medicines management pharmacist at the hospital, said: "The unit works more efficiently because we ensure that the drugs are correct on admission, and prepare discharge prescriptions so that patients are sent home more quickly. The medical and nursing staff appreciate our expertise, and have provided strong support."

According to Alison Ewing, Royal Pharmaceutical Society Vice-President and clinical director of pharmacy at Royal Liverpool and Broadgreen Hospitals NHS Trust, many hospital pharmacy departments will now have to change their on-call arrangements to comply with the EWTD. She added: "This may clearly be a challenge for some, but this could be an opportunity to introduce shift working and provide an extended clinical pharmacy service for longer hours. With junior doctors' hours also being reduced, pharmacists can look to extend their roles further provided appropriate funding can be found."

Further information on the DoH guidance is available from **www.doh.gov.uk/workingtime/Ecj.htm**

The European Working Time Directive

- No more than 48 hours work a week (averaged over a reference period)*
- Eleven hours continuous rest in 24 hours
- Twenty-four hours continuous rest in seven days (or 48 hrs in 14 days)
- Twenty-minute breaks in work periods of over 6 hours
- Four weeks annual leave
- For night workers, an average of no more than eight hours work in 24 over the reference period.

* An employee may sign a waiver agreement with his or her employer if he or she wishes to work more than the maximum permitted hours.

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Medication errors addressed in report

Strategies to reduce medication errors are set out in a report published recently by the Department of Health. The report, entitled "Building a safer NHS for patients: improving medication", sets out detailed information as to the nature and causes of errors and provides empirical recommendations and examples of current good practice designed to influence practice at a local level. Chief pharmacists are among the report's stated target audience.

The report details the types of errors commonly made in the prescribing, dispensing and administration of medicines, with pharmacists' roles in preventing these being recognised. In addition, the challenges associated with specific patient groups (eg, patients with allergies, seriously ill patients and children) and types of medicines (eg, anaesthetic agents, anticoagulants, cytotoxic drugs, intravenous infusions, methotrexate, opiate analgesics, and potassium chloride) are highlighted. Organisational and environmental issues, such as improving the labelling and packaging of drugs and enhancing communication at the primary and secondary care interface, are also addressed. Key recommendations are included throughout.

When announcing the report, Lord Warner, undersecretary of state for health pointed out that: "A prescribed medicine is the most frequent treatment provided for NHS patients, so ensuring that drug treatment is safe is key."

The report is welcomed by the National Patient Safety Agency, an organisation promoting many initiatives that are in line with the report's recommendations. According to David Cousins, head of safe medicines practice at the NPSA: "The report will be extremely helpful to all working with medicines in the NHS. It summarises many of the safety problems with medicine use, and provides a focus and driver for change."

The Royal Pharmaceutical Society has also welcomed the report, with President Dr Gill Hawksworth emphasising the Society's commitment to the Government's patient safety strategy.

The full report is available from **www.doh.gov.uk/buildsafenhs/medicationsafety/index.htm** [The DoH web address is to change — see p45].

Examples of key recommendations

- Have clear procedures for documenting allergies
- Implement electronic prescribing systems with automatic alerts
- Use readily distinguishable wristbands for patients with known allergies
- Do not take oral and intravenous drugs to a patient's bedside at the same time
- Include details of age, weight and the intended dose in mg/kg on all prescriptions for children
- Standardise the range of chemotherapy infusion devices, preferably through centralised equipment libraries, and ensure that support and training in their use is provided for staff
- Communication about methotrexate dose regimes should be clear and explicit, and dispensing and prescribing computer systems should incorporate alerts to prevent inappropriate daily dosing
- Limit the range of opiate analgesics used in primary and secondary care
- Have standardised charts or, preferably, validated computer software for calculating the doses and infusion rates for potent drugs such as digoxin and opiates