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It is time we shared good practice in supplementary prescribing

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It would appear, given the relatively small number of potential supplementary prescribers being trained, that hospital pharmacy has been slow to seize this new opportunity. Hospital pharmacy has historically been the ideal environment to develop new practices and pharmacist prescribing is a good example of this. Almost 20 years ago pharmacists were involved in managing anticoagulant clinics, counselling patients and adjusting doses.¹ Although this was innovative practice then, it is now a feature of many hospital pharmacy services. However, the legislative framework at the time did not allow pharmacists the freedom to prescribe — trusts had to develop systems to ensure that what was being done was legal and within a clinical governance framework. We now have the legislative framework in supplementary prescribing. A SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis is often used in business planning and may provide an understanding of the reasons for this slow uptake.

STRENGTHS

Pharmacists are the experts on medicines (or so we say). Pharmacists are taught more therapeutics than any other health professional, including doctors. Most hospital pharmacists have or are working towards a postgraduate clinical qualification and under Agenda for Change pharmacists even at a junior level score highly on the knowledge and skills

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criteria. In hospital we have access to patient medical notes and are generally regarded as an integral part of the health care team. Furthermore, our training encourages evidence based practice, we promote safe, rational and economic prescribing and are at the centre of the medicines management agenda. Therefore, it would seem logical for us to be in the vanguard of supplementary prescribers.

WEAKNESSES

The framework for supplementary prescribing requires a clear diagnosis and an agreed management plan. These are criteria which are best suited to primary care and chronic disease management. Where hospitals are operating chronic disease management clinics, involving pharmacists, then there is an obvious role for us to be supplementary prescribers.

However, the NHS has also moved on over the past few decades and hospitals are much more centres of acute care than ever before. Thus it is in this arena that hospital pharmacists are struggling to interpret the framework since, in the acute situation, a management plan is more fluid and patients often have a number of clinical problems which may need attention.

OPPORTUNITIES

Medicines are involved in nearly every health care intervention in hospital. Over the past decade the number of medicines prescribed in the community has risen significantly. Although no detailed data are available for hospital prescribing, the statistics are likely to be even more dramatic, since our patients are

usually sicker. Clearly there must be opportunities for pharmacists to prescribe even in the acute setting.

One or two scenarios do tend to lend themselves to supplementary prescribing in hospital. Apart from pharmacists working in outpatient clinics (eg, anticoagulant or hypertension), pharmacists working as members of the hospital nutrition team will probably be carrying out most of the role of the prescriber for total parenteral nutrition. Similarly oncology and aseptic services pharmacists are in an ideal position to adjust doses of chemotherapy, according to pre-determined protocols, in order to help speed up preparation and facilitate the patient's journey through the clinic. These are obvious areas where the pharmacist has considerable expertise and can make a real contribution to patient care. However, it is the less obvious areas of work where we need to share experiences.

THREATS

We must acknowledge that there are scenarios where other health care professionals, particularly nurses, could claim to be better placed to act as supplementary prescribers. There have been nurse specialists in chronic disease management clinics for many years (eg, diabetes). It could be argued that where the range of medicines is limited and the nurses' understanding of the disease and its long term management is good, they may be better placed than the pharmacist to be prescribers in this area. Furthermore, there are many more nurses than hospital pharmacists, and they have been a powerful lobby in driving non-medical prescribing forward.

THE WAY FORWARD

From the preceding analysis it is clear that there are opportunities and challenges for hospital pharmacists to be supplementary prescribers. As reported in this issue of *Hospital Pharmacist*, the foundations are being laid for consultant pharmacists. As it is envisaged that this new breed of pharmacist will spend approximately 50 per cent of their time as a clinical specialist, it is reasonable to expect them to be prescribers, as well as specialist advisers. Furthermore, work is already under way to pave the way for pharmacists to be independent prescribers. This is likely to fit better with acute treatments and hospital care. Logic dictates that the first wave of independent prescribers will come from existing supplementary prescribers and, if we follow the pattern of the nurses, training may result in dual qualification. Therefore, if we do not get involved in supplementary prescribing, we may miss the opportunity to establish pharmacists as prescribers.

What is needed is for practitioners in the vanguard of supplementary prescribing to share their experiences with others. The *Hospital Pharmacist* is an ideal forum to do this. Your experiences will help your colleagues become involved in their own hospital setting and establish pharmacist prescribing as the norm rather than the exception. To quote from Mikhail Gorbachev, the architect of Russia's perestroika, "If not us, who? If not now, when?"

REFERENCES

1. Bourne J, Pegg M. Pharmacy contribution to outpatient management of oral anticoagulants. *Pharmaceutical Journal* 1987;238:731-5.