

A year in the life of a supplementary prescriber

By Mark Tomlin, MRPharmS

It is now just over a year since the first hospital-based pharmacists registered as supplementary prescribers with the Royal Pharmaceutical Society. This article looks at how and why one pharmacist took on this role and examines the impact it has had on his day-to-day working life



Over a year has passed since pharmacists began working as supplementary prescribers in UK hospitals

I am a clinical pharmacist, specialising in critical care, so to be registered as a supplementary prescriber might seem bizarre. Supplementary prescribing is designed primarily for chronic disease management, and not this area of acute and dynamic medicine. However, as has been pointed out, hospitals are becoming even more centred around acute care, and so adapting supplementary prescribing to this setting is important if the full benefits from the practice are to be realised.¹

I have therefore taken Ray Fitzpatrick at his word, when he asked that supplementary prescribers share their experiences with others.¹ In this article, I explain why I became a supplementary prescriber and how the arrangement has been put into practice at Southampton General Hospital. I also point out how having the power to prescribe has benefited my working life and patient care. Some information relevant to this issue has already been included in a recent *Hospital Pharmacist* special feature about clinical nutrition.²

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Impetus for change

Before supplementary prescribing was in place at Southampton General Hospital, I was a clinical pharmacy manager who developed a clinical pharmacy service for the whole trust using service-level agreements.³ When the service was initially rolled out, pharmacists had much to learn from clinicians about diseases and prescribing in practice. However, pharmacists were still able from the start to apply their pharmaceutical knowledge to benefit patient care. Guidelines and protocols were put together and pharmacists became involved in activities such as clinical audit and intervention monitoring for patients requiring nutrition.

It quickly became clear that pharmacists were making many interventions each week and that in excess of 95 per cent of these were being accepted by medical staff. Hence we constructed an "empowerment document" to allow pharmacists to act on their interventions without the need for junior doctor approval. This was possible because the interventions were effectively "acting under the directions of a doctor", in this case the consultant leading the team. Because we were implementing the consultant's plan we

were, in effect, acting like junior doctors. Documentation was made in the notes and the junior doctor signed the chart to make the amendment legal. They had the option to correct or change what the pharmacist had written, but rarely did so, because this was their consultant's plan after all. We called this process, which was implemented in 1998, "therapeutic substitution".

There were benefits for formulary management and financial control in adopting therapeutic substitution, but the primary motivation was risk management. This coincided with the start of implementing clinical governance arrangements at Southampton General Hospital. I was among those who made presentations to the clinical management team and trust board on pharmacists' intervention and risk management at an early stage of the process.

I was asked to give risk management lectures to nurses undertaking the newly created nurse prescribing courses at Southampton University. This was interesting because most nurses were aware of drug administration errors, but not the way that prescribing itself can introduce errors. Those nurses who had seen me advise doctors about parenteral nutrition thought that I

already had prescribing rights. I was often asked why I was not a prescriber. Throughout the time I gave the lectures, I was able to change my answer from excuses to a positive statement that I would become a prescriber as soon as it was legal for pharmacists to do so.

— Training

The first supplementary prescribing course to become available was at King's College London, where the nurse prescribing course already running at the institution had been adapted to accommodate pharmacists. Being taught with a cohort of nurses was an informative experience. In the drug selection component, the pharmacists casually gave the answers, while the nurses flicked through the British National Formulary. In the patient assessment section, the nurses casually demonstrated how it was done for the pharmacists. It was clear from this that there were different training needs for pharmacists and nurses, and also for those working in primary and secondary care.

It is important to note that the role of supplementary prescribing courses is to teach participants the law and the process involved — they do not teach therapeutics *per se*. Before starting the programme, I had already been on an intensive course on nutrition and several courses on pharmacokinetics and therapeutic drug monitoring.

In April 2004, I passed my examinations and registered with the Royal Pharmaceutical Society as a supplementary prescriber. I changed my job description and updated my professional indemnity insurance. Within a week of registering, I started prescribing.

— Prescribing at last

I chose to prescribe in the therapeutic areas in which I was already advising doctors (ie, parenteral nutrition and therapeutic drug monitoring). Parenteral nutrition advice had reached the stage where I wrote out the formulation of parenteral nutrition and the rate at which it was to be delivered on a patient's drug chart and the doctor just added his or her signature. I had been doing this for over five years. If parenteral nutrition was needed for a patient, I was bleeped to come and write it up. Being given prescribing rights was therefore only a small step forward in practical terms, but psychologically it made a big difference.

Senior house officer and registrar anaesthetists' rotations in intensive care last one to three months. When I qualified as a supplementary prescriber, the then current medical team readily accepted my role once I had explained it to them. The senior registrar was a particular enthusiast for pharmacist supplementary prescribing, although it was initially the consultant who authorised the clinical management plans for each patient. Junior

doctors were invariably delighted when I volunteered to organise parenteral nutrition for their patients, because it was less for them to do. It also removed the "farce" of them signing a prescription that contained details which they often did not understand.

The next major medical staff rotation was in June. The first ward round was taken by a consultant anaesthetist, who had been my designated medical practitioner for the course, and was also the director of the intensive treatment unit (ITU). He introduced me to the junior medical staff as "the pharmacist who prescribes". He went on to say that, because he had authorised me to prescribe for patients, the junior doctors were to do as I said. After that, I was treated differently. I am asked many more questions now than I was before I started prescribing and I am paged more frequently. The doctors asked me for prescribing advice in the same way that they would ask their consultants for advice about other aspects of a patient's management.

I also find that I now write much more in patients' notes. This is both to initiate the supplementary prescribing process for a particular patient and to describe how the treatment plan develops as their needs change. This makes a good legal record of what is intended.

Managing workload is an important part of my day-to-day job. Supplementary prescribing is not practical for all patients — particularly when the patient is only going to be on the ITU for a limited time because, for example, they are transferring to another ward or hospital. In these circumstances, I still write the parenteral nutrition prescription but get a doctor to sign it off, as before.

— Other roles

For therapeutic dose monitoring, I am often the person who writes up the treatment plan in a patient's notes. The prescribing workload, however, is shared between supplementary prescribers and doctors, mainly because I do not work weekends (drug levels sometimes need to be changed over weekends and I tend to leave written advice to medical staff about what action to take). Sharing prescribing works well — doctors often hand over patients direct to me rather than me having to ask other doctors or retrieve data from the notes.

I have also become something of an adviser on non-medical prescribing teaching courses, particularly in explaining the difference between patient group directions (PGDs) and supplementary prescribing. One issue that is worth consideration is whether dose modification in pharmacist-led anticoagulant clinics should still be run under PGDs, now that supplementary prescribing is a reality.

I now also teach junior doctors nutrition, therapeutic dose monitoring and fluid management as part of their induction training.

There is also a lot of interest in supplementary prescribers and those working in this way should expect to be part of research projects looking at roles and how they develop.

— Future

Junior doctors' training has changed and there is a clear need for clinical pharmacist support. Prescribing is often not seen as a shared duty by them. Many think of prescribing initially as their domain, until they have the opportunity to see supplementary prescribers at work. Computerised prescribing is in place in many hospitals. These systems must be designed to recognise supplementary prescribers and enable them to perform all the tasks within their role (such as ordering a test).

— Conclusion

Supplementary prescribing can be made to work well in an acute care setting, even though it was not designed with this in mind. In many ways, becoming a supplementary prescriber makes only a small practical difference to how pharmacists work. However, in my experience, it has increased the efficiency of the prescribing process, which benefits patient care,⁴ and enhanced the standing of pharmacists in a clinical team.

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