

# Medicines management review to be included in trust ratings

Medicines management is to be the subject of review by the Healthcare Commission. It will be assessed along with diagnostic services and admissions management in the annual assessments (ratings) for trusts in England for 2005/6.

This review will follow on from the "A spoonful of sugar" report in 2001, the previous acute hospital portfolio review on medicines management 2001/2 and the 2003 Department of Health self-assessment framework. The aim will be to generate benchmarking data which will provide a direct comparison between trusts.

The framework on which the ratings for medicines management will be based is intended to identify areas for improvement and ascertain the drivers of good performance. The Healthcare Commission will consult widely with trusts and other bodies before making a final decision about which indicators these should be.

The review will investigate corporate governance structures supporting medicines management, including management of budgets and expenditure. Aspects such as clinical governance, evidence-based practice,



Medicines management will be assessed from a patient's perspective

modernisation of service delivery, patient experience and staff development will also be included.

The review consists of a core questionnaire using existing routine national data sources (eg, trust financial returns to the DoH and IMS health data). There will also be a medicines management mini-clinical audit, a clinical or ward team satisfaction survey and an outpatient waiting time audit.

The data collection will take place from September to mid November 2005 via a new web-based system with the national report and full benchmarking data to be published in May 2006.

Ray Fitzpatrick, clinical director, Royal Wolverhampton Hospitals NHS Trust and chair, Royal Pharmaceutical Society's Hospital Pharmacists Group commented that "this high profile review by the Healthcare Commission will push medicines management up the corporate agenda. Trusts where medicines management is not performed at the right level will be highlighted and I hope this will help lead the development of medicines management services in those organisations."

More information can be obtained from the website [www.healthcarecommission.org.uk/acutehospitalportfolio](http://www.healthcarecommission.org.uk/acutehospitalportfolio)

## brief

Pharmacy technicians should register with the Royal Pharmaceutical Society according to three national organisations. The Guild of Healthcare Pharmacists, the Association of Pharmacy Technicians UK and the Society's Hospital Pharmacists Group recently published a joint statement on technician registration (*The Pharmaceutical Journal* 2005;274:792).

The National Patient Safety Agency is seeking examples of best practice in the management of inpatient anticoagulation. Hospital pharmacists with examples of practice, including the competencies and training required to deliver a service, should contact Christine Clark, who has been appointed as project pharmacist (e-mail [chris@salt.u-net.com](mailto:chris@salt.u-net.com) or telephone 07968 928584).

Contributors of articles to *Hospital Pharmacist* are now required to grant a licence for publication to the Royal Pharmaceutical Society. A copy of the new publishing licence is printed on p279.

Links to websites that list registrations of forthcoming clinical trials are being made available on the website of the Association of the British Pharmaceutical Industry. The URL is [www.abpi.org.uk](http://www.abpi.org.uk)

Several London hospitals are to stock more tetanus vaccines, hepatitis B vaccines and ketamine for emergency supply in the event of a major incident. This follows the demand for these agents in the recent London bombings. While no hospitals reported depletion of stock in this incident, more would be required in the event of higher casualty count (*The Pharmaceutical Journal* 2005;275:1).

## SACAR publishes hospital antimicrobial guideline template

Good practice in developing hospital antimicrobial guidance is set out in a template published by the prescribing sub-group of the Specialist Advisory Committee on Antimicrobial Resistance (SACAR).

The template provides advice on the background and introduction to guidance and how antimicrobials should be categorised according to prescribing restrictions. It also suggests common infections for

which a treatment regimen should be provided and situations where guidance should be given on antimicrobial prophylaxis.

"Everyone involved in the monitoring of prescribing of antimicrobials should consult the guidelines", said Jonathan Cooke, chair of the prescribing sub-group of SACAR and chief pharmacist, South Manchester University Hospitals NHS Trust. Dr Cooke pointed out that the Healthcare Commission could

use this template as a basis for assessing medicines management services (see story above). The template is reproduced on p280.

□ Around 90 per cent of antimicrobial pharmacists have come into post since extra funding from the Department of Health was announced in 2003. This is according to Hayley Wickens, senior microbiology pharmacist, St Mary's Hospital, London, who has analysed the clinical pharmacy initiative.

# Critical care career pathway approved

Critical care pharmacy practice took a step forward with the Department of Health approval of a specialist career pathway. The DoH document, "New ways of working — adult critical care specialist pharmacy practice", issues guidance on the practice, skills and experience needed by pharmacists wishing to specialise in adult critical care. This provides a clear outline for the career path as a critical care pharmacist from foundation to consultant pharmacist.

The aim of the DoH is to improve the outcome of critically ill patients by delivering high quality pharmacy services and ensuring pharmacists are trained within a recognised competency framework for the NHS. The document also identifies the need for different levels of

practice, peer review and support from colleagues in a critical care network (or equivalent).

The guidance states that, in order to achieve these objectives, roles need to be defined, expertise shared, specialist competencies identified and new standards of working adopted.

Catherine McKenzie, principal critical care pharmacist at Guys and St Thomas' Hospital NHS Foundation Trust commented that "this will help pharmacists gain the experience needed to provide optimum pharmaceutical care to critically ill patients." She also believed that "the support for an agreed career path for critical care pharmacists will contribute to the development of a national template for consultant pharmacists."

# Good compliance with NPSA potassium alert

Adherence to the National Patient Safety Agency (NPSA) alert for the storage and handling of concentrated potassium solutions is good according a recent report (*Quality and Safety in Healthcare* 2005;14:196). Researchers from the University of York evaluated 207 clinical areas in 20 randomly selected acute NHS trusts in England and Wales.

The study, which involved interviews and inspections of clinical areas, found 100 per cent compliance with storage requirements (ie, vials in a locked cupboard separate from other injectables) and 98 per cent of areas did not contain unauthorised stocks of potassium.

All trusts documented control of potassium chloride in clinical areas. However, there were

documentation errors in 10 per cent of these areas. During interviews, 78 per cent of nurses and only 30 per cent of junior doctors were aware of the alert.

The researchers concluded that the NPSA alert was effective and resulted in rapid development and implementation of local policies to reduce the availability of concentrated potassium chloride solutions. However, they warned that, "cost, lack of storage space, inconsistent availability of some of the newer, stronger solutions and difficulties in accessing concentrated potassium chloride out of hours may contribute to its return". They also advised that continued vigilance of pharmacy departments with annual random checks will maintain this standard.

# Interim guidance published on hazardous waste regulations

Interim advice on dealing with new hazardous waste regulations, which came into effect on 16 July, has been published. The Hazardous Waste (England and Wales) Regulations 2005 implement many European directives. The interim guidance has been written by a group including the NHS Pharmaceutical Quality Assurance Committee, the Royal Pharmaceutical Society, the Pharmaceutical Services Negotiating Committee, the Environment Agency and care home representatives.

The regulations cover the storage, carriage, processing and supply of waste. A breach of the regulations is a criminal offence with fines of up to £20,000 and terms of imprisonment of up to six months.

The guidance states that most prescription-only medicines will no longer be classed as hazardous — the exceptions being cytotoxic and cytostatic medicines. Until an authoritative list of drugs which are classed as hazardous waste is produced for the UK, pharmacists are advised to use a US list included in the guidance. Every person who produces or stores hazardous waste must notify their premises to the Environment Agency (this



Hazardous and non-hazardous waste must be separated for disposal

will normally be done by the trust waste management department).

The guidance states the mixing of different types of hazardous waste, and the mixing of hazardous and non-hazardous waste, is now prohibited. This means that pharmacies will need at least two containers — one for cytotoxic or cytostatic waste, and one for other waste.

A list of medicines that do not have hazardous properties will be produced. These medicines are suitable for disposal in the sewer or landfill site.

Colin Ranshaw, chair of the working group on hazardous waste set up by the NHS Quality Assurance Committee, commented that “all hospital

pharmacists should read the guidance, as the new regulations change the way waste is dealt with, and failure to comply can lead to a criminal conviction.” Mr Ranshaw emphasised that other health care professionals who handle medicines, such as nurses and doctors, should also be aware of the changes. Final guidance on complying with the new regulations is due in September and Mr Ranshaw encouraged pharmacists to send him comments on the interim document (e-mail [Colin.Ranshaw@CardiffandVale.wales.nhs.uk](mailto:Colin.Ranshaw@CardiffandVale.wales.nhs.uk))

The interim document can be viewed online on the practice section of the Society’s website at [www.rpsgb.org/practice](http://www.rpsgb.org/practice).

## HPG supports devolution

National boards of the Royal Pharmaceutical Society for England, Scotland and Wales have been endorsed by the Society’s Hospital Pharmacists Group in its response to the devolution consultation. The committee commented that the Scottish and Welsh executives have provided better communication with members and these benefits should also be applied to England.

The committee called for reserved places for pharmacists from each sector on each board, noting that the current Council of the Society lacks the breadth of expertise from all sectors. To ensure continuity, the committee did not support appointment solely by election. It also proposed input from other groups such as the British Oncology Pharmacy Association and the UK Clinical Pharmacy Association.

At its meeting on 11 July, the committee also heard about a presentation from its chair, Ray Fitzpatrick, to the Society’s practice committee. Professor Fitzpatrick had also made a presentation to the new members of the Society’s Council on issues relevant to the practice of hospital pharmacy.

# Preregistration trainees given AfC pay increase

The preregistration trainee national profile for Agenda for Change is to be in band 5. Current preregistration trainees whose posts match the national profile will have a salary rise from £14,189 to £15,877 backdated to October 2004. They will receive a further increase backdated to April 2005. Graduates starting in August 2005 will have a starting salary in the range £16,389 to £18,698, depending on the stage of assimilation in their trust. They will also be entitled to an increment after six

months, in line with other entry level posts (salary scale shown in panel).

The Guild of Healthcare Pharmacists has stated that it agreed to the profile reluctantly. It is concerned that the title of the profile — pharmacist entry level — may be confusing during the matching process. It is also concerned that the profile does not fully recognise the range of skills and responsibilities of the post, with inconsistencies when compared with the entry level pharmacy technician post. The points of

contention include the factors for physical skills, responsibility for patient care, responsibility for human resources and responsibility for information resources.

David Miller, chair of the Guild’s terms and conditions committee, commented, “although there are concerns, we know they do not affect the outcome of the band”.

| Band 5 pay scales (points relevant to preregistration trainees) |                         |
|---|-------------------------|
| October 2004 salary scale                                       | April 2005 salary scale |
| £15,877 (*)   | £16,389 (*)             |
| £16,516 (*)   | £17,049 (*)             |
| £17,049 (*)   | £17,598 (*)             |
| £18,114   | £18,698                 |
| £18,647   | £19,248                 |

(\*) denotes transitional point which will ultimately disappear

# Monoclonals guidance published

Updated guidance on the handling of monoclonal antibody products has been produced by the NHS Pharmaceutical Quality Assurance Committee. This is to

replace the initial guidance issued by the National Centralised Intravenous Additives Service Group and the British Oncology Pharmacy Association (*Hospital Pharmacist*

2001;8:153). Richard Needle, chief pharmacist, Essex Rivers Healthcare NHS trust said that “this will be relevant to all hospital pharmacists, particularly those involved in aseptic.”

## Guidance on handling of monoclonal antibody (MAB) products

This document is issued under the cover of the NHS Pharmaceutical Quality Assurance Committee and has been produced by the committee in agreement with the Pharmaceutical Aseptic Services Committee (formerly the National Centralised Intravenous Additive Service Group) and the British Oncology Pharmacists Association.

### Gene therapy or monoclonal antibody

Gene therapy, or more correctly gene transfer therapy, involves the deliberate introduction of genetic material into somatic cells for therapeutic, prophylactic or diagnostic purposes.

Monoclonal antibodies do not act in such a manner that they cause any transfer of genetic material and their effect is at a functional rather than genetic level. Monoclonal antibodies are not infective. Therefore a fundamentally different approach is required towards the handling of the two classes of substance.

Handling of gene therapy products will be covered in a new chapter to be included in the fourth edition of the “Quality assurance of aseptic preparation services” book.

### Monoclonal antibodies

These agents affect a wide range of biological functions in a potentially profound manner. Those handling them should be aware of the nature of each product used and specific associated problems.

These recommendations are based on considerations of operator protection from contamination and patient protection from cross contamination. Ideally, the manipulation of monoclonal antibody preparations should be undertaken in pharmacy aseptic facilities, in accordance with the recommendation of the Breckenridge Report.<sup>1,2</sup> It is however acknowledged that this will not always be possible in the case of monoclonals, as a number of these products may be administered in the community.

There is a theoretical risk of operator sensitisation to these products as they are proteinaceous in nature.

However, there is currently little evidence to suggest that this is a problem in practice at this time.

Production methods of some products may leave traces of non-human protein elements — typically murine — which may also potentially cause operator sensitivity on repeated exposure.

### Policy Statement

Monoclonal antibodies may be manipulated in existing aseptic facilities, provided that adequate segregation from other products is achieved by the normal levels of process control expected within pharmacy aseptic units and the application of standard validated cleaning procedures.

This document supersedes other recently published guidance.

Ideally these products should be handled on a campaign basis, but it is accepted that due to workload pressures this will not always be realistic.

Consideration must also be given to specific hazards associated with individual products. Thus it will always be necessary to consider the mode of action of individual agents before introducing them into pharmacy aseptic units.

### References

1. The Breckenridge Report (HC 76/9). London: Department of Health; 1976.
2. Audit Commission. A spoonful of sugar — medicines management in NHS hospitals. London: Audit Commission; 2002.

## Corrections

- Reference 3 on p232 of the June issue was from the *Australian Journal of Hospital Pharmacy* and not as stated.
- Mark Howell's e-mail address is [mark.howells@burtonh-tr.wmids.nhs.uk](mailto:mark.howells@burtonh-tr.wmids.nhs.uk), and not as stated on p197 of the June issue.
- The answer to question 5e on the May Life-long

Learning was false. Some of the answer sheets that were sent out incorrectly identified the answer to this question. Certificates received by 4 July will have an error of 1 in the score, depending on the answer given to 5e. Scores will be corrected in the database that is used to record scores.

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