

A career as a medical admissions pharmacist

By Haley Hill, MRPharmS

Following the *Hospital Pharmacist* conference reports covering the topic of “bridging the gap” across the primary and secondary care interface, this article looks at a role based on the edge of this interface — a medical admissions pharmacist



Completing an accurate drug history is often a complex task

The admission process is a time when important clinical decisions are made. During the first 24 hours of stay, the patient’s drug chart is completed and generally a diagnosis is made during the post-take ward round. A pharmacist’s input is invaluable at this stage of patient care. This article, based on interviews with medical admissions pharmacists from several hospitals within the NHS, discusses pharmacists’ involvement in ensuring correct drug histories are taken and appropriate medicines are prescribed for presenting and pre-existing medical complaints.

Background

Following publication of the Government’s emergency care targets many NHS hospitals set up units to which they could admit patients who require beds. Such units comprise emergency medical units, clinical decision units, surgical admission units and medical admission units (MAUs).

“The exact use of these units varies from trust to trust,” said Sarah-Jane Hill, highly specialist medical admissions pharmacist, St Thomas’ Hospital, London. She explained that, for example, in some trusts the MAU is interchangeable with the clinical decision unit. However, this article focuses on pharmacists’ roles within the specific field of medical admissions.

Haley Hill is staff editor at *Hospital Pharmacist*

Medical admission unit

The MAU generally takes acute medical patients referred from the accident and emergency department, where the patients stay until stabilised for discharge or referred to another ward. “There is a high turnover with many patients moving within 24 hours,” said Anna Drinkwater, admissions and discharge pharmacist, University Hospital of North Staffordshire. “Pharmacists have to work quickly and thoroughly to ensure that treatment protocols appropriate for the individual patient have been followed right from the start,” she said.

Ms Hill said that you have to deal with any acute medical condition with which a patient presents. However, she added: “The most common admissions we get are acute exacerbations of chronic obstructive pulmonary disease, alcohol withdrawal, pneumonia and epileptic seizures.”

Drug history

“A full and accurate drug history is essential for a drug review to be carried out,” said Ms Hill. She noted that a local audit conducted at St Thomas’ hospital showed that 50 to 60 per cent of drug charts were written incorrectly. She explained that when errors occur on the drug chart on admission, they are often carried through the patient stay and, if unnoticed on discharge, can continue into the primary care setting and may contribute to the patient being readmitted to hospital.

“Admissions pharmacists are also ideally placed to assess patients’ own medicines and any compliance issues associated with the medicines,” said Ms Hill. “Pharmacists are able to discuss the medicines with the patient and assess their beliefs and it is in this situation that compliance issues are often highlighted.” She also explained that, when talking to the patients, there is an ideal opportunity to advise on other issues such as smoking cessation. “Patients are often more receptive to the idea of quitting smoking if they have just been admitted to hospital because they are worried about their health,” she explained.

Interventions

Admissions pharmacists often take part in post-take ward rounds. “This enables pharmacists to provide input, and guide therapy

Panel 1: The UKCPA Emergency Care Pharmacists Group

The group intends to:

- Provide education and training events
- Share clinical experience and evidence
- Encourage and support practice research
- Monitor and maintain standards of practice
- Provide clinical expertise to new and existing pharmacists and technicians working in emergency care

Career history — Mari Davies

Mari Davies began her career in August 2001 as a preregistration trainee at Chesterfield and North Derbyshire Royal Hospital. During this year she completed on-site clinical rotations and attended weekly training sessions at the Queen's Medical Centre in Nottingham. "I think my clinical knowledge improved greatly during this year and I learnt about one-stop dispensing, patient self-administration of medicines and reuse of patients' own medicines," she said.

In August 2002, Ms Davies took a post as rotational pharmacist at the Great Western Hospital, Swindon. It was a grade A-C progression post and she rotated through dispensary, medicines information and manufacturing. She also covered wards of various specialties such as respiratory, gastrointestinal and cardiology. "I enjoyed being able to see a range of specialties so I could get a better idea of which field I

would like to specialise in," she explained. Ms Davies was in this post for three years, and during this time she completed the University of Bath diploma in clinical pharmacy practice. She said: "This job helped to increase my confidence as a pharmacist. It also helped me to develop my time management skills and taught me how to prioritise my workload.

"Having spent three years as a rotational pharmacist, I decided that I wanted to specialise in medicine. However, I felt that it was too early in my career to specialise in one area of medicine, and felt that an admissions pharmacist post would be the perfect job," she said. In August 2005, she took her current post as medical admissions pharmacist at Llandough Hospital in Vale of Glamorgan. "I get to see a wide range of medical patients and therefore keep my knowledge up to date in a number of fields," she said.

at the beginning of the patient stay," said Ms Hill. "Often there are pharmaceutical issues with the patient that the medical team are unaware of and that can have an important impact on diagnosis and subsequent treatment."

If an incomplete drug history has been taken, medicines that may be partly or fully responsible for the presenting complaint may be overlooked. An example given by Ms Drinkwater was a patient presenting with hypotension. She explained that the drug history she took revealed that the GP had recently started the patient on angiotensin converting enzyme (ACE) inhibitor therapy. The dose prescribed was too high for initiation of therapy resulting in severe hypotension. She commented that, if the drug history had not been complete and the medical team were unaware of the ACE inhibitor therapy, the treatment and outcome could have been inadequate. She said that had this not been highlighted, it is likely that the patient would have been restarted on the ACE inhibitor by the GP once discharged, increasing the chances of readmission.

Ms Drinkwater said that an audit carried out at her hospital showed that 18 per cent of admissions were medicine-related. "This included side effects, overdoses, etc," she explained. "This shows how important pharmaceutical input is on admission — the sooner the better," she said.

Communication

Nicola Wake, lead pharmacist for medicine, North Tyneside General Hospital said that communication is vital in this role. She explained the importance of good communication with primary care in order to

obtain an accurate drug history on admission. "It is equally important on discharge to ensure continuity of medicines and care," she said. She added that communication between admissions pharmacists and pharmacists on the base wards is also necessary to handover any relevant issues to ensure that the patient is monitored appropriately.

Mari Davies, medical admissions pharmacist, Llandough hospital, Cardiff and Vale NHS Trust, said that, in her role she has developed good relationships with doctors, nurses and other health care staff working in the MAU. She said that attending the post-take ward round has enabled her to develop a rapport with the consultant and gain respect from the rest of the medical team. "We also help train the house officers," she added.

Rewards

The role of an admissions pharmacist is varied and provides broad-based knowledge and experience. The field covers all acute medical conditions, often with underlying chronic disease states. "There are many interesting cases and you learn a lot from working with many different consultant teams with different specialties — it is a steep learning curve," said Ms Drinkwater. "You have to think fast on your feet and the turnover of patients is immense," she said.

Ms Hill pointed out that as the experience you gain in this role is so diverse and broad-based, there are many opportunities for development and progression. "The only drawback to working in this role is that you only get a brief period to monitor the patient and you do not always get to find out the outcomes of your interventions," she said.

Future

Ms Wake said that the future is very much that of an emergency care team. "Our accident and emergency pharmacist and admissions pharmacist are both part of the same team," she said. She explained that, in the future, this team will become out-reach, aiming to visit patients in their own homes, tackling any medicine-related issues before they lead to hospital admission. "Independent prescribing is an opportunity for pharmacists to become more central to the multidisciplinary team," she added.

Ms Wake is chair of the United Kingdom Clinical Pharmacy Association Emergency Care Pharmacists Group (see Panel 1, p445). She explained that the group was formed with the aim of bringing emergency care best practice together in primary and secondary care.

Career history — Anna Drinkwater

- July 1993–July 1994 — preregistration training at Boots the Chemist, Arnold, Nottingham
- July 1994–April 1995 — relief pharmacist for Boots the Chemist covering stores in the Nottingham area
- April 1995–August 1996 — relief manager for Boots the Chemist covering stores in the Leicester area
- October 1996–March 1998 — Voluntary Services Overseas, working as a pharmacist at a district hospital in South Africa
- April 1998–July 1998 — locum pharmacist at Peterborough District Hospital
- July 1998–July 2000 — rotational pharmacist at the Princess of Wales Hospital, Bridgend. Completion of the University of Wales clinical diploma
- July 2000–April 2001 — locum pharmacist at various hospitals and community pharmacies in Jersey
- April 2001–May 2003 — clinical pharmacist (grade C) at Alexandra Hospital in Redditch
- June 2003–September 2004 — admissions and discharge pharmacist (grade D) at University Hospital of North Staffordshire, Stoke-on-Trent
- October 2004–present — admissions pharmacist and anticoagulant manager (banded 8a according to Agenda for Change) at University Hospital of North Staffordshire, Stoke-on-Trent