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A career as a . . . falls prevention pharmacist

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Pharmacists' unique skills in medication review are invaluable in the falls prevention setting. In this article Jeremy Robson describes a typical week in his role as falls prevention pharmacist at The Leeds Teaching Hospitals NHS Trust

Falls prevention is a rapidly changing and challenging field both on a national level and locally in Leeds. The sixth National Service Framework for Older People states that action should be taken to prevent falls and reduce resultant fractures or other injuries[1]. Pharmacists can play a key role in this field by conducting medication reviews, assessing patient's medication needs and assisting with any concordance issues in order to help prevent falls.

In 2003 the pharmacy department at The Leeds Teaching Hospitals NHS Trust received funding for the expansion of orthopaedic services. Following this an interface pharmacist post was introduced to contribute towards implementing the national service framework. The post was designed to provide medication reviews on the twice weekly orthopaedic elderly care ward rounds and to introduce a pharmacist presence at the weekly multidisciplinary falls clinics. Jeremy Robson is the pharmacist currently holding the post and in this article he explains what the role involves and describes a typical week for him at the trust.

Jeremy Robson is interface pharmacist for elderly medicine and orthopaedic surgery, **Gill Sunderland** is clinical pharmacy team leader for elderly medicine and orthopaedic surgery and **Phil Deady** is former clinical pharmacy team leader at The Leeds Teaching Hospitals NHS Trust

A typical week

On Monday morning I prepare for the first falls prevention clinic at Chapel Allerton Hospital in Leeds. The secondary care falls service has run a weekly clinic for approximately four years, but funding has now been secured for twice weekly clinics and it is hoped that this will increase to five times a week in the near future.

At the clinic, I liaise with the nursing staff to discuss which patients are priorities for me to see. It is now accepted that interventions to prevent falls have to be targeted and individualised to the patient. This has led to the different health care disciplines working more closely together and has allowed me to gain an insight into the skills that other health care professionals have.

I decide which patient I am going to see first and look at the referral and other clinical information. It is important to obtain the clinical background to enable me to maximize pharmaceutical care. The clinic is often busy and all disciplines have to work together. For example, if a physiotherapist is seeing a patient, I have to be prepared to see another patient and vice-versa.

I ensure that each patient has a complete drug history (including over-the-counter and herbal drugs). As well as confirming what a patient is currently taking, it is important to establish which medicines have been started or discontinued in the last six months. This information is compared with the patient's falls history, to see if there is any correlation.

I conduct a medication review using the information I have available (ie, medical notes, primary care information, what the patient says, referral letters, etc). However, it is accepted that a full medication review would require access to other sources such as GP records and should also be conducted in the patient's own home. The patients are encouraged to bring their medicines with them to clinic but typically this does not happen. This is an area that I am looking to improve and may involve the conduction of domiciliary visits and collaboration with primary care colleagues. A practice pharmacist is due to accompany me at one of the clinics in the near future.

I ensure patients are prescribed "bone prophylaxis" in the form of calcium (1 gram) and vitamin D3 (800units) supplementation with or without a bisphosphonate, in accordance with the current National Institute for Health and Clinical Excellence guidelines. At present calcium and vitamin D3 are not generally prescribed unless the patient has had a previous fracture, or has been diagnosed as having osteopenia or osteoporosis. The clinic has a peripheral dual energy X-ray absorptiometry scanner which gives an indication of whether a patient has osteopenia or osteoporosis.

An example of my work here is when I contacted a community pharmacist to explain why he should not put a patient's bisphosphonate in a compliance aid with the rest of the morning medication. This prevents correct administration and

Career history — Jeremy Robson

Jeremy Robson completed a sandwich degree course at Bradford University which involved a six-month placement in the second year at Boots The Chemists and a six-month placement in the final year at The Norfolk and Norwich Hospital in Norwich.

Between 1999 and 2002 he took on a resident pharmacist post at Doncaster Royal Infirmary. During this time he completed the Bradford University diploma in clinical pharmacy.

"Doncaster Royal Infirmary is a busy district general hospital and helped me develop skills in time management, organisation, prioritisation and coping with working under pressure," said Mr Robson. "I was able to demonstrate initiative and lateral thinking, but also learnt when it was appropriate to ask for advice." He explained that these skills have been valuable throughout his career and he has continued to develop them.

In 2002 Mr Robson took the position of medicines management pharmacist at Rotherham General Hospital.

"As well as providing a clinical pharmacy service to acute surgery wards, my main role was to develop and implement medicines management initiatives. I was the lead pharmacist in producing the pharmacy department's protocol and rolling out the use of patient's own medication on wards," he explained. He said that for this role he had to use effective communication and influencing skills, to enable the pharmacy and ward staff to change their practice.

In 2003 Mr Robson left Rotherham General Hospital and became rotational pharmacist at The Leeds Teaching Hospitals NHS Trust. "An opportunity came to study for the doctor of pharmacy at Bradford University, which enabled me to develop as a specialist practitioner through reflective practice," he said. He explained that this taught him skills such as practising evidence-based medicine and the importance of self directed learning. "I am currently in my third year of the DPharm and thinking about my research project. I rotated through clinical areas of medicine for the elderly and respiratory medicine, before being appointed to my current post as interface pharmacist for elderly medicine and orthopaedic surgery at The Leeds Teaching Hospitals NHS Trust last January."

subsequently reduces or prevents absorption of the bisphosphonate.

Next I return to the Leeds General Infirmary to review the patients on my orthopaedic and elderly wards, whom I did not have time to see before the clinic.

My ward commitments include an orthopaedic surgical ward and a medicine for the elderly ward (acute stroke ward), thus fulfilling my interface role. On Tuesdays and Thursdays I attend the "medicine for the elderly liaison consultant ward rounds" on the orthopaedic wards. We usually see patients over 80 years old with fractures (generally hip fractures), who have unresolved medical and social problems.

My role is to conduct a medication review with the consultant, deal with compliance issues and advise on bone prophylaxis. In the past, orthopaedic patients would not have had a falls medication review by a pharmacist and would have been discharged once they were fit enough after surgery.

Falls discussion group

Any pharmacists interested in falls prevention or who have a similar role are invited to contact Jeremy Robson with the view to setting up a discussion group. He can be contacted at:

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In The Leeds Teaching Hospitals NHS Trust there are plans to open designated orthopaedic elderly medicine wards and there will be a reversal in the way that the patients will be cared for. The elderly fracture patients will be admitted under the care of an elderly medicine consultant, with the orthopaedic surgeon visiting to resolve the orthopaedic problem(s). This will benefit pharmacists because they will have an opportunity to conduct more in depth medication reviews and take on supplementary prescribing roles.

I have few formal falls prevention duties on Wednesdays. This week, I undertake my usual ward commitments, meet with my diploma student to discuss her progress and then conduct a stroke workshop for the postgraduate diploma students.

On Fridays I attend the second falls prevention clinic of the week. When I arrive I discuss a few points relating to a preregistration trainee's project I am supervising, with the consultant. The project involves investigating the prescribing of bone prophylaxis to patients before and after they attend the falls prevention clinic.

An example of a patient requiring a pharmacist's intervention is a woman who presented with at least one fall a week for the past couple of months. She had a history of depression and other psychiatric problems and was prescribed amitriptyline 100mg at night and fluoxetine 40mg in the morning. This combination had been prescribed five years ago and appeared to not have been reviewed since. Also, on questioning the patient, I learnt she had recently been taking St John's Wort as she had read in a magazine that it was good for depression. Her GP was unaware of this. I counselled her to stop taking it and she was referred for a psychiatric review.

I advised the consultant on how to stop the amitryptyline in order to minimize the risk of withdrawal symptoms. As an aside, I also discovered that she was overdosing on paracetamol. She had been buying a common branded preparation from her supermarket as well as taking her prescribed paracetamol.

After the clinic I complete some paperwork and DPharm coursework. This is developing my reflective practice and research skills. Next year, as part of the course I will be conducting a two-year research project, which I hope to undertake in the area of falls prevention.

Benefits and challenges

My role is an integral part of a specialised multidisciplinary team. This has helped me to appreciate the different skills of other professionals and I enjoy the fact that we are working together for the benefit of the patient. I enjoy having a specialist role that is also varied. I provide input from the falls clinic on ward rounds and I also cover other clinical areas as part of my ward commitment such as acute stroke and orthopaedics. Also, there is potential to develop my role further: for example, I have just started a supplementary prescribing course.

One of the main challenges of my role is that the medication reviews I conduct at the clinic are often incomplete. I do not have access to GP records and I do not visit the patient in their own homes. This means I am often giving advice and making decisions based on incomplete drug histories which can be challenging at times. I am currently liaising with my primary care colleagues in order to improve communication issues. For example, forwarding my medication review form with the consultants letter so it can be recorded in the patient's records in primary care.

There is great scope for pharmacists input to help prevent falls and no matter how simple an intervention I make, it is likely to have an important impact on the care of these patients. With supplementary prescribing and other increased responsibilities, my role is constantly evolving and I enjoy the day-to-day and long term challenges of implementing falls prevention within a multidisciplinary team.

References

1. Department of Health. National Service Framework for Older People. The Department: London; 2001.