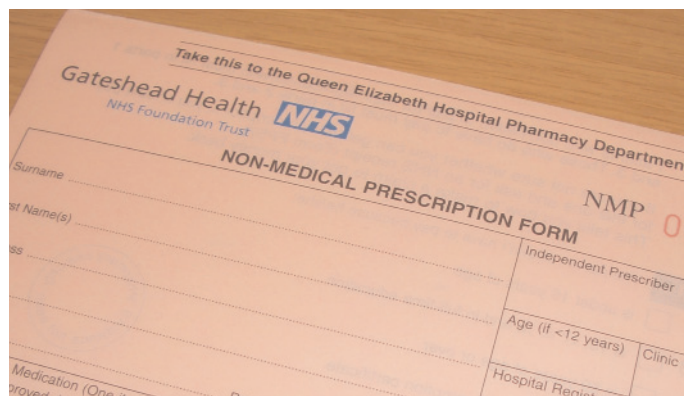


# A career as ... a supplementary prescriber

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Eight pharmacists are currently registered as supplementary prescribers at Gateshead Health NHS Foundation Trust. This article describes their roles, in order to provide an insight into the opportunities presented by this way of working



Non-medical prescription forms are used by supplementary-prescribing pharmacists at Gateshead Health NHS Foundation Trust

**P**harmacists' skills have long been recognised by the Department of Health, but it is only recently that changes in national legislation have prompted new approaches to delivering patient-centred pharmaceutical care.

Gateshead Health NHS Foundation Trust (GHNFT) currently has eight pharmacists registered as supplementary prescribers, who are actively engaged in providing a diverse range of prescribing services across the trust. Through this article, we hope to demonstrate how pharmacists, working in extended roles, can work safely and effectively within multidisciplinary teams to provide services to outpatient clinics, intermediate care facilities and wards.

## Outpatient clinics

**Rheumatology clinic** The rheumatology supplementary prescribing clinic accepts triaged (ie, allocated on the basis that most improvement is likely to be achieved) referrals

from primary care of patients with mechanical back pain, radicular back pain and neck pain. It is led by a supplementary prescribing pharmacist and a clinical specialist physiotherapist, working together in extended clinical roles.

The role of the supplementary prescribing pharmacist is to confirm the patient's medication history, perform a thorough medicines review, screen for any possible contraindications, agree a clinical management plan (CMP) with the patient and the clinic consultant, and prescribe any appropriate medicines. Most newly-referred patients will be offered a number of follow-up appointments. At these, the supplementary prescribing pharmacist will review the effectiveness of any pharmaceutical intervention made at the clinic, and either adjust the dose of existing medicines or introduce new medicines in accordance with the CMP.

**Diabetic hypertension clinic** The pharmacist-led diabetic hypertension clinic was commissioned following a discussion within the diabetes team that highlighted a group of patients who would benefit from receiving care from a prescribing pharmacist. This clinic accepts consultant-triaged referrals for patients, identified from the annual review clinics who:

- Are over 40 years old
- Have diabetes with uncontrolled hypertension
- Have no evidence of aortic stenosis or severe renal impairment

During the consultation, the pharmacist measures the patient's blood pressure and offers support about healthy lifestyle issues and smoking cessation. A full medicines review is performed and a CMP is agreed using local and national evidence-based guidelines. Within this framework, medicines can be prescribed or adjusted as appropriate. A follow-up appointment is made and any appropriate blood tests are arranged. Patients are discharged back to a primary care setting once their target blood pressure has been achieved and sustained for two months.

**Anticoagulation clinics** The anticoagulation service in Gateshead provides 19 primary care clinics and six secondary care clinics, serving the needs of 2,500 patients. All referrals to the service are handled centrally by secondary care staff, with patients being transferred to an appropriate secondary or primary care clinic, all of which are run by the pharmacists at GHNFT. Supplementary prescribing is about to be implemented, in addition to using the existing patient group direction arrangements. This will ensure that over-anticoagulated and under-anticoagulated patients can receive appropriate, convenient and timely treatment, with vitamin K and low molecular weight heparin, respectively. As part of this initiative, all prescribing pharmacists have received training in phlebotomy and subcutaneous drug administration. This enables them to provide an

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efficient and convenient point-of-care service to patients.

A further development is a review clinic to assess the risk-benefit of anticoagulation therapy in individual patients who have multiple risk factors. This is especially important in older people who, as a group, have been shown to have both a higher rate of major bleeds and a higher thromboembolic risk.

### Intermediate care

Intermediate care services bridge the gap between hospital care and primary or community care. In Gateshead there are currently 15 intermediate care residential beds, in Ravenswood rehabilitation unit. Patients are admitted from hospital or their homes for short term rehabilitation (up to six weeks).

All patients staying in the intermediate care beds have their medicines reviewed on admission by a clinical pharmacist. A CMP is agreed with the community geriatrician, which allows the prescribing of both the patient's regular medicines and a range of products for minor ailments. If a specific medicine needs to be reviewed during a patient's stay, for example, analgesics or anti-hypertensive drugs, this can also be included in the CMP.

Any changes that are made to regular medicines by the prescribing pharmacist are documented and communicated to the relevant GP on a medicines discharge summary. This promotes the safe and effective transition from intermediate care to primary care.

### Ward-based prescribing

Ward-based prescribing is arguably the most difficult aspect of supplementary prescribing. Currently, pharmacists are practising in two areas at GHNFT, with a third at the planning stage.

**Critical care** Several pharmacists are already using their supplementary prescribing qualification in critical care departments around the country.<sup>1,2</sup> A pharmacist-led supplementary prescribing service to critical care patients is currently being rolled out at GHNFT, following the finalisation of the trust's position about patient consent. It is a legal requirement to obtain a patient's consent before supplementary prescribing is implemented — but the vast majority of critically ill patients are unable to provide this. GHNFT has therefore adopted the practice of "treating in the patient's best interests", in line with the policy used by medical teams when treating patients in critical care departments.

The pharmacist prescribes standard medicines, such as those found in the "care bundles" for ventilated patients (eg, venous thromboembolism prophylaxis), and in the relevant components of the internationally-

sponsored "surviving sepsis" campaign guidelines. In addition, the CMPs that are drawn up allow simple analgesics, nicotine replacement therapy, electrolyte replacement therapy and prokinetic agents to be prescribed. The aim of the supplementary prescribing service to critical care patients is to support the senior medical team in ensuring that medicines are prescribed appropriately and consistently. Daily ward rounds are carried out by a highly skilled multidisciplinary team, and provide an excellent forum from which an effective and efficient supplementary prescribing service can be implemented.

**Elderly care** The care of the elderly team has adapted the Department of Health's CMP template so that it can be completed quickly when a patient is admitted to the rehabilitation wing at GHNFT (the Jubilee Wing). Basically, the CMP allows pharmacists to prescribe a variety of medicines for the diagnosed problems listed. The list has been produced in conjunction with an elderly care consultant in response to perceived problem areas of prescribing. Pharmacists can add medicines to a drug chart on admission, once an accurate drug history has been taken and, for example, add osteoporosis treatment for patients who are deemed at risk, using a specially designed tool. Consent is gained from each patient and the consultant on the ward round signs the CMP as the patient is being reviewed. The pilot service has been running for about three months and feedback has been positive. The consultant physician on the ward made the following comments: "Early experiences of supplementary prescribing in our busy district general hospital would suggest that it can contribute to improving patient care. In areas, for example the treatment of constipation, a condition both extremely prevalent and the source of much anxiety and distress, it can be of paramount importance, particularly in the elderly and postoperatively in those on opioid analgesics. Traditionally, most junior doctors are asked to prescribe laxatives and enemas, often when the patient has developed relatively severe symptoms. The supplementary prescriber can work with the patients at a much earlier stage and proactively manage this common condition, and can prevent the need for suppositories and enemas, which the patients often find distressing and embarrassing."

**Oncology** Cancer patients receiving adjuvant chemotherapy are an ideal target group for pharmacist-led supplementary prescribing. The patient would be assessed initially by an oncologist who would recommend the most appropriate regimen and agree a CMP with both the patient and pharmacist. The pharmacist would then calculate the dose from the patient's body surface area and prescribe the chemotherapy and any supportive

treatments (eg, antiemetics), reviewing the patient at defined intervals to assess any side effects and plan the next cycle of treatment. The Northern Cancer Network Pharmacist Group is currently working on developing CMPs to fit this process.

### Moving forward

Since the introduction of supplementary prescribing, pharmacists at GHNFT have been expeditious in making use of this initiative. A trust-wide non-medical prescribing (NMP) policy has recently been approved. This requires non-medical prescribers to be approved by the trust's Drug and Therapeutics Committee. When approved, the prescriber's name is added to the trust's NMP register, a certificate of registration is issued and a NMP prescription pad is supplied.

As the number of non-medical prescribing roles commissioned within GHNFT increases, so to does the demand for CPD events to meet the needs of the prescribers. The NMP lead co-ordinates training days and workshops for all registered prescribers at the trust, which help develop clinical skills and knowledge on a wide range of clinic topics. Representatives from the National Prescribing Centre present these.

Supplementary prescribing was designed primarily for the management of long-term chronic conditions. Our pharmacist-led hypertension and rheumatology outpatient clinics clearly fit this model, and, for us, it has been the use of supplementary prescribing to support the care of inpatients that has proved particularly difficult to implement.

We have, however, managed to introduce a substantial component of supplementary prescribing to many different specialities in the hospital. These are in the main, ad-hoc opportunistic interventions, over and above other routine prescribing. The real benefits of non-medical prescribing in hospitals will only come when we can show that there are wards and departments where non-medical prescribing accounts for the majority of prescribing, allowing medical resources to be redeployed. This is presumably more likely to occur following the implementation of independent prescribing, which is likely to be under way shortly. Of course, independent prescribing will itself bring challenges and questions, such as whether a pharmacist independent prescriber can draw up a CMP for a supplementary prescriber to follow.

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