

A good starting point

— for medicines management arrangements

By Alison B Ewing, FRPharmS

So, the Health Care Commission has delivered its verdict on our hospital medicines management arrangements. It is helpful that there has been recognition of the importance of appropriate medicines management by the commission and the need to assess its effect on patient care.

The commission classed 18 trusts as excellent and 12 as weak, with the rest being somewhere in between. We should look at this exercise as the beginning of a process to raise the standards for medicines management in the acute sector rather than an absolute measure of excellence. In order to do this, we must put the true clinical picture of what really happens in a trust on top of this statistical picture — looking at the measurements in terms of the changing NHS.

One area considered in the report was dispensing for discharge. This process reduces workload and improves patient care. It is an excellent measure of the improvement in services that has happened in recent years. There are still some pockets of resistance to this change but I feel that the undoubted benefits make it a good measure of progress for pharmacy services. Chief pharmacists who have not been able to progress with this initiative will be able to use the audit to their advantage to make trust managers see that there is a need to implement this system and that the resources required should be supported.

Automation was also reviewed and some progress has

Alison Ewing is clinical director of pharmacy, Royal Liverpool & Broadgreen University Hospital NHS Trust

been made across the country. Although finance is one barrier to implementation, there is a need to re-engineer the whole dispensing process to include 28-day packs as the norm. With current staffing difficulties, this may not be possible in the short term, but, again, the report will be useful to those trusts that are lagging behind.

There is no doubt that completing the commission's questionnaire was time consuming. It involved co-operation from those working in finance, information and IT departments, as well as pharmacy staff. The clinical pharmacy audit itself was not popular with pharmacists who were busy providing ward services. It was also, to a certain extent, arbitrary since there seems to have been differences in what was recorded by different trusts.

One contentious issue, I believe, is using the number of clinical interventions as a measure of the effectiveness of the clinical pharmacy service. Where is it written that the more interventions carried out, the better the clinical pharmacy service? I cannot agree with that assumption. I hope that I have put in place in my trust an education system for doctors and non-medical prescribers that will allow them to "get it right first time more of the time". We have developed high quality prescribing protocols with a support package of education for nursing staff. These activities should reduce the need for pharmacists to make basic interventions and allow them to concentrate on patient care. I think that the intervention measure should be put into this context to have greater meaning.

Self medication is another "problem". As one who was

involved with projects to enable elderly patients to self-medicate in the early 1990s, I am well aware of the benefits to staff and patients but in this current climate of shorter hospital stays and more day surgery, there are fewer patients who will be in hospital long enough to go through the assessment system.

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The report states that 69 per cent of trusts said patients could not self-administer on at least a fifth of wards. Trusts need to identify the patients who should have the option to self-administer medicines and allow them to do so. Perhaps, instead of excluding just those patients in, for example, the accident and emergency department and intensive care unit, we should concentrate on looking only at those who would really benefit from self-medicating, such as the elderly and those with long term conditions who are in and out of hospital.

Other areas such as education and training were assessed in the report but little was disseminated about their quality, apart from absolute measures. Perhaps we should delve deeper into the available funding for pharmacist and technician development, which is sparse compared to the structured approach to medical education and training across the whole NHS.

But what will trusts be doing as a result of the report? This will vary from trust to trust, depending on the initial status of their medicines management. I imagine that those determined as "weak" will have some explaining to do and I hope that this will be a catalyst for change in these cases. Those deemed "excellent" should be sharing their best practice with others in a structured way.

In my own trust, the executive board has discussed the report with the auditors who prepared our personalised report. This allowed for a healthy debate and provided another opportunity to fly the flag for more funding. It has also strengthened the case for maintaining current pharmacy staff levels in these days of potential job losses.

On a pharmacy-wide scale, the result of the information gained from this huge exercise should be a co-ordinated approach to setting some benchmarks and for the next audit to measure progress towards these gold standards.

We now have a picture of the state of medicines management and it seems encouraging — but to quote the Healthcare Commission chief executive Anna Walker: "There is room for improvement." Improvement means support from management and we must use the information we have to maintain and expand pharmacy services in the present-day climate of "efficiency savings".

Hospital Pharmacist conference

"Medicines management in the spotlight — learning from the health check" is the title of the next *Hospital Pharmacist* conference, to be held on 1 February 2007. For further details see p327.