

# Chief pharmacists call for more collaboration and leadership

Collaboration and leadership in the establishment of the new professional body for pharmacists have been called for by the UK's four chief pharmacists.

Speaking at the opening session of the Guild of Healthcare Pharmacists and United Kingdom Clinical Pharmacy Association joint conference, held in Brighton at the end of last month, Keith Ridge, chief pharmaceutical officer for England said that implementation of the White Paper: "Trust, assurance and safety: the regulation of health professionals", would require an "all-embracing redesign" of professional regulation and lead to a lasting settlement between the professions and the public. Collaboration with other professions will be needed but where medicines are involved

pharmacists should be taking a lead, he said. The profession must come together and seize the opportunity, he concluded.

Norman Morrow, chief pharmaceutical officer for Northern Ireland, urged radical thinking. "Consider a college of the Isles to serve all four home countries," he said.

Bill Scott, chief pharmaceutical officer for Scotland, welcomed the current "bloodless revolution" in community pharmacy that is shifting the basis of payment from dispensing volume to clinical care. He called for partnership between hospital and community pharmacists to develop clinical services further. He emphasised the need for strong leadership to deliver the vision and to advocate professional pharmacy skills to

patients and to paymasters. This would be one of the roles of a future college. A college would have to reflect its constituents' ambitions, he said.

Existing pharmacy organisations, such as the guild and the UKCPA, have much to contribute to a future college, suggested Carwen Wynne Howells, chief pharmaceutical adviser for Wales. They have large, voluntary memberships and already provide pharmacists with leadership, practice skills and expertise. The development of practice standards could be one of their potential inputs to the future college, she said.

Further coverage of the GHP/UKCPA conference will appear in the next issue of *Hospital Pharmacist*.

## brief

■ "How healthy is your hospital?" is the question posed by the recently launched 2007 Hospital Guide, compiled by Doctor Foster Intelligence. Among the findings is that some trusts do not have an antibiotic pharmacist in post — only 25 per cent of trusts in Wales have an antibiotic pharmacist, compared with 91 per cent of trusts in southern central England. Further details are available at [www.drfooster.co.uk](http://www.drfooster.co.uk).

■ Training events (sponsored by Baxter) aimed at those involved in implementing the recent National Patient Safety Agency alert on safer use of injectable medicines are to be held on 13 June (in London) and 25 June (in Harrogate). Attendance is free of charge. Further details are available by e-mailing: [patient\\_safety\\_uk@baxter.com](mailto:patient_safety_uk@baxter.com)

■ A summary of the first meeting of the National Patient Safety Forum (held on 14 February) is available from the Department of Health website. It is also accessible via *PJ Online* ([www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)).

■ Decision-making methods used by the National Institute for Health and Clinical Excellence are currently under review. Consultation on the revised draft is expected to begin in November.

■ Results from the Healthcare Commission's latest (2006) annual NHS staff survey, taking into account the views of staff from 326 trusts, have been published. They can be accessed via *PJ Online* ([www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)).

■ The Central Office for Research Ethics Committee has been renamed the National Research Ethics Service (NRES).

## APTUK/AAH hospital technician of the year 2006 winners presented

A project to promote the safe, rational and prudent prescribing of antibiotics in Northumbria Healthcare Foundation NHS Trust has won the clinical category of the Association of Pharmacy Technicians UK/AAH Hospital Service Technician of the Year Award 2006.

Sonia Burns, pharmacy technician specialist for quality and performance at the trust, helped co-ordinate the work, which involved preparing an antibiotic formulary, a handbook for the treatment of common infections and an intravenous to oral switch policy. Audits to monitor adherence to antimicrobial policy were also performed and training programmes were established. Before the initiative, no designated individual or group was responsible for monitoring or improving the use of antimicrobials at the trust.



Margaret Vass (left) and Sonia Burns, with their APTUK/AAH awards

Margaret Vass, lead community services technician at Lyne Bank Hospital, NHS Fife, won the supply chain category award for a project improving cold-chain procedures for vaccines. As a result of auditing cold-chain systems, educating staff and using a refrigerated delivery

vehicle to distribute vaccines to clinics, less stock now needs to be destroyed.

Miss Burns and Mrs Vass were presented with their awards at the APTUK conference held in Birmingham last month.

A further report from the APTUK conference can be found on p172.

# Pharmacists best at detecting adverse drug events from charts

When reviewing drug charts, pharmacists are better than other health care professionals at detecting harm caused by the use of a drug. This is the conclusion of a study published in the *American Journal of Health-System Pharmacy* (2007;64:842-9).

The authors identified 13 studies that fully met their inclusion criteria (eg, contained an appropriate definition of an adverse drug event [ADE], were not limited to specific drugs or types of ADEs, and the identified chart reviewers' professions) from a systematic literature review. Meta-analysis showed that the mean weighted ADE rate detected by pharmacists was 0.33 per admission, which was significantly higher than the 0.16 per admission detected by non-pharmacists (doctors in all but one study in which nurses and trained medical records



Medical records are reviewed by pharmacists when checking for ADEs

administrators carried out the review).

When ADE surveillance studies are to be carried out in hospitals, pharmacists are well-placed to perform these, the authors suggest. They also note that, when reviewing charts,

pharmacists consider details from medical records, as well as from drug orders and laboratory values. Any automation of chart review to reduce the cost of ADE surveillance would need to incorporate this activity, they advise.

## Computers do not guarantee patient safety

Using computers to calculate drug doses does not necessarily prevent human error from occurring, according to the authors of a recent *BMJ* case report (2007;334:851-2).

The report describes a dose error made when using a handheld computer to calculate paediatric doses, as a result of the concentration of the drug in a formula cell being mistakenly overwritten with a patient's weight. The authors explain that formula cells cannot be locked in PocketExcel (used in handheld devices), unlike in the desktop version of Excel. They note that other software programs for calculating doses are available but do not tend to be as user-friendly as those based on Excel. Double-checking of computer-generated doses by a colleague should be routine practice, they conclude.

## Drug naming conventions explained

**International** non-proprietary names (INNs) should be useable in as many languages as possible and therefore should not contain the letters "ph" ("f" should be used instead), "h," "k," "ae," or "oe". This is among the information presented in a comment in *The Lancet* (2007;369:1326-8) that details how drugs are named.

The authors point out that, even when all the naming rules are complied with, adopting INNs can contribute to errors. For example, when British Approved Names were changed to INNs (as a result of a European Directive) mercaptamine (previously cysteamine) was confused with mercaptopurine, and levothyroxine (previously thyroxine) was confused with liothyronine.

## Pharmacists are key to upholding guidelines

**Interventions** by clinical pharmacists are an effective means of encouraging doctors to adhere to prescribing guidelines that are designed to reduce the incidence of chronic heart disease in patients admitted to a US hospital with acute myocardial infarction.

A study, published in *Archives of Internal Medicine* (2007;167:586-90) used computerised alerts to identify patients with elevated troponin I levels to hospital pharmacists. For those assigned to the study group, a pharmacist assessed whether they were receiving all the medicines detailed in the relevant prescribing guidelines and contacted the patient's doctor with recommended interventions if they were not.

Patients in the study group were significantly more likely to be discharged on a regimen

including angiotensin converting enzyme inhibitors and statins. There was no significant impact of pharmacist interventions on beta-blocker or aspirin use.

The authors suggest that with ongoing pressure to improve the care of patients with coronary heart disease, their approach could be a model for increasing adherence to evidence-based guidelines. Computerised physician order entry clinical decision support technology might ultimately be used to promote adherence to prescribing guidelines, the authors note. However, such technology is not fully developed and interim approaches are needed. Moreover, computerised prompts might be less likely to be taken note of than reasoned advice from a colleague, they suggest.

## Elderly drug burden index developed

**A drug burden** index for use in older people has been developed by US researchers and published in *Archives of Internal Medicine* (2007;167:781-7).

The researchers used existing studies and pharmacological principles to devise a formula to examine the association between medicine use in the elderly, and physical and cognitive performance. When evaluating the index in a community population, they found that exposure to medicines with anticholinergic or sedating effects was linked to impaired function, but that taking several different drugs *per se* was not. They suggest that validation of the index in other elderly populations could lead to it being used in evidence-based prescribing.