

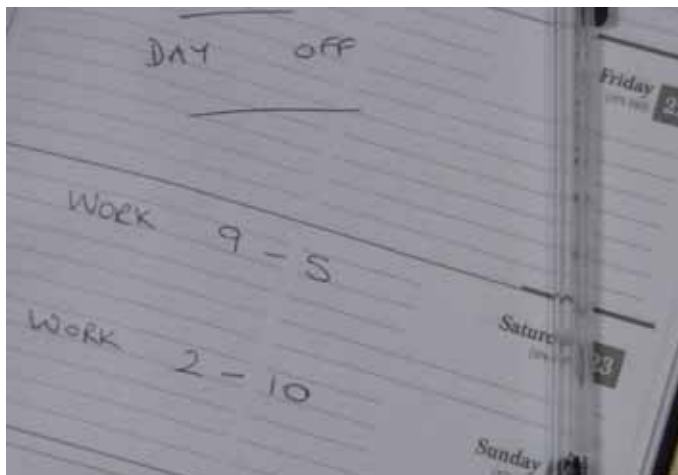
Pharmacist-led reconciliation backed by draft NICE guidance

A pharmacist should be involved in reconciling a patient's medicines as soon as possible after admission to hospital, according to draft guidance issued by the National Institute for Health and Clinical Excellence.

In collaboration with the National Patient Safety Agency, NICE examined all available evidence for using medicine reconciliation systems, and agreed that using a medicine reconciliation template was effective in preventing medication errors at the point of hospital admission. Moreover, the involvement of a pharmacist offers the benefit of medicine review, in addition to medicines reconciliation.

The guidance says that information technology (IT) systems could be used to reduce the risk of transcription errors, and improve communication between primary and secondary care.

However, IT cannot replace the need for a trained person checking what the patient is actually taking, and that it is prescribed appropriately.



Hospital pharmacies may provide an admissions service seven days a week

David Cousins, head of medication safety at the NPSA, commented: "There is already worldwide recognition that medicines reconciliation is important. However for the first time, this guidance is acknowledging the evidence that involving a pharmacist within a few hours of a patient's admission can bring about additional benefits."

He went on to confirm that many hospital pharmacies already employ pharmacists in admissions

units, however they may need to consider extending this service to seven days a week. He concluded: "Individual trusts need to examine the pattern of their own medication incident reports, to compare how many occurred when a pharmacist was involved in reconciliation, and how many occurred when they were not."

Draft guidance can be accessed via *PJ Online* (www.pjonline.com/hp). The final guidance is expected to be published in December.

brief

■ NHS hospitals will face spot checks where there is concern that older people are not being treated with dignity. A new report published by the Healthcare Commission shows that trusts are generally putting appropriate systems in place, but improvements are needed. The report can be accessed via *PJ Online* (www.pjonline.com/hp).

■ Performance of NHS foundation trusts over the first quarter of 2007 is detailed in the latest report from Monitor, the independent regulator for trusts. It highlights the financial strengths of the trusts and the number which have failed to achieve their predictions. It can be accessed via *PJ Online* (www.pjonline.com/hp).

■ Hammersmith Hospitals NHS Trust and St Mary's NHS Trust have merged, and have strengthened the existing links with Imperial College, to form Imperial College Healthcare NHS Trust. The new trust will comprise five hospitals — Charing Cross, Hammersmith, Queen Charlotte's and Chelsea, St Mary's and the Western Eye.

■ An "innovation council" has been announced by health minister Lord Darzi. The council will be given £100 million to help the NHS develop innovation across several categories, including pharmaceuticals. Lord Darzi's interim report on "Our NHS, our future" was due for publication shortly after *Hospital Pharmacist* went to press.

■ An online toolkit to encourage better hydration for hospital patients has been launched by the National Patient Safety Agency and the Royal College of Nursing. Available via *PJ Online* (www.pjonline.com/hp).

New deal on pensions for NHS staff

Details of the new NHS pension scheme have been announced by NHS Employers. The final agreement has been reached after a four-year review conducted with health care trade unions, the NHS Pension Scheme and the Department of Health.

Key features of the new scheme include:

- A final salary scheme with an accrual rate of 1/60th for each year of service
- A normal pension age of 65
- A lower contribution rate for the lowest paid staff, while the highest paid staff will pay an additional 1.5 to 2.5 per cent on their contribution rate
- A larger contribution rate for the majority of staff, increased by 0.5 per cent to 6.5 per cent
- Calculation of the final salary by averaging the highest paid three consecutive years during the last 10, allowing members to reduce their workload in the final years before retirement without reducing their pension
- No mandatory lump sum on retirement, but the option to take up to 25 per cent of the pension as a lump sum, with annual pensions adjusted accordingly
- Survivor pension rights extended to non-married partners
- The flexibility to take all or part of the pension while continuing to work and build up more pension

Existing staff can remain on the old scheme, or accept a one-off opportunity to join the new scheme, which will become mandatory for all staff joining the NHS after 1 April 2008.

Anthony Oxley, president of the Guild of Healthcare Pharmacists said: "This is a very good piece of negotiating by the NHS unions. However we urge existing members to read the final details when they become available and consider their own situation before deciding which scheme is best for them."

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New NHS regulator to deal with hygiene

A new hospital regulator that will have the power to impose fines and halt new admissions to hospital wards in England for failing to meet hygiene requirements has been announced by Health Secretary Alan Johnson.

The regulator replaces three existing bodies (the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission) as part of the forthcoming Health and Social Care Bill. It will be the first time that NHS and independent health care providers are regulated under the same framework.

The new regulator will begin by ensuring Prime Minister Gordon Brown's call for a one-off deep clean in hospitals is initiated. The intention is to restore hospitals as closely as possible to their original state.

Mr Johnson also announced that hospitals will adopt a "bare

below the elbows" dress policy, in an attempt to ensure good hand and wrist washing. The policy suggests that long sleeves, wristwatches and hand or wrist jewellery should not be worn when providing patient care, because they can become contaminated with micro-organisms and may reduce compliance with hand hygiene regulations. Staff are also advised not to wear white coats or neck ties when providing patient care.

However, an article in *The Lancet* accuses the British government of "pandering to populism" instead of using evidence to deal with hospital acquired infection. The article states that instead of removing visible dirt and accosting doctors for wearing long sleeves and watches, hospitals should concentrate on keeping "high touch" surfaces clean and ensuring all health care staff wash their hands properly.

NHS progress is mixed, patient reports show

Over the past five years the NHS has improved significantly in some areas, including reducing waiting times, but there are mixed results in other areas such as hospital hygiene, according to a new report from the Picker Institute.

"Is the NHS becoming more patient-centred?" describes trends from 26 surveys of NHS patients in England undertaken in 2002-07. The report says that in 2006, fewer patients leaving hospital felt that they had been told "completely" about the purpose of their medicine than in 2002 (*Hospital Pharmacist* 2007;14:181). However, mental health trusts reported an improving trend, with 65 per cent of patients saying they had been told "completely" about their medicines in 2007, compared with 63 per cent in 2005. Patients also report that

health professionals are not giving them sufficient information about the potential side effects of their medicines.

The report states: "Despite pockets of excellent practice the service as a whole is still far from patient-centred. The most significant problem is the failure of clinical staff to provide active support for patient engagement."

□ Also published last month is the Health Foundation's report "Patient and public experience of the NHS", highlighting areas in which patient expectation has been met, and areas that need improving. The report includes data from the Commonwealth Fund for 2005 showing that 26 per cent of patients had not had a thorough medicines review in the previous two years. The reports can be accessed via *PJ Online* (www.pjonline.com/hp).

Pharmacy input improves blood sugar control

Pharmacist input into diabetic therapy can significantly improve blood sugar control, new research shows.

In what the researchers believe to be the first meta-analysis investigating pharmacists' interventions in diabetes patients, they performed a literature search and identified 36 studies meeting their eligibility criteria. The pharmacy interventions most commonly seen were patient education and medicines management, and the studies were conducted in settings including hospital wards, medical clinics, and community pharmacies.

The researchers found that haemoglobin A_{1c} was sensitive to improvements from pharmacy intervention from both clinical and statistical perspectives. Fasting plasma glucose levels and systolic blood pressure were found to be "possibly sensitive" to pharmacist interventions, and lipid levels, adherence, knowledge and quality of life were "probably not sensitive" (*The Annals of Pharmacotherapy* 2007;41:1569-82).

Errors reduced by automated medicines management system

Prescribing and medicine administration errors are reduced by the use of an integrated electronic medicines management system, recent research shows.

Analysis of the impact of the ServeRx system (manufactured by MDG Medical), which combines electronic prescribing with automated dispensing, bar-coded administration and an electronic administration record, has shown that prescribing and administration errors are reduced by almost half.

Data were collected three to six months before installation of the system at a London teaching hospital, and six to 12 months afterwards. Prescribing errors were reduced by 47 per cent (from 3.8 per cent to 2 per cent) and the researchers say that a further reduction may be possible with additional decision support.

They say: "It may be that the errors avoided are those that pharmacists usually correct, but electronic prescribing ensures that they are always correct before the first dose is due and has the potential to allow



Ward-based automated dispensing is part of the ServeRx system

pharmacists to concentrate on other aspects of the usage of medicines."

Non-intravenous administration errors were reduced by 39 per cent, predominantly wrong dose and omission errors. The researchers say this is likely to be due to the design of the automated dispensing system and trolley, giving nursing staff access only to the product prescribed.

Nurse checking of patient identity was also found to

increase and may have resulted in more prescribing errors being corrected before administration.

The time spent by pharmacy and medical staff dealing with medicines increased, although the nursing time spent on drug rounds was reduced.

The researchers note that it is important to estimate the harm avoided by such systems, which may be disproportionate to the reduction in errors (*Quality and Safety in Health Care* 2007;16:279).

Doctors unaware of medicine costs

Doctors have a poor understanding of how much drugs cost, according to a new systematic review.

Researchers undertook a systematic literature search for studies in which doctors were surveyed about how much they thought drugs cost. Their analysis (which involved 24 articles) showed that only 31 per cent of estimates of drug cost were within 20 or 25 per cent of the true cost. Less than half of the estimates were accurate by any definition of cost accuracy, and the median estimate was 243 per cent away from the true figure. Overall, doctors consistently overestimated the cost of inexpensive products and

underestimated the cost of expensive ones.

Most of the studies were conducted in the UK, Canada and the US. They say that although a direct comparison between countries was not possible because the studies were not conducted simultaneously, estimation accuracy does not appear to differ among the three countries.

"Despite substantial and increasing concern about costs, doctors' awareness has not improved in the 26-year span of these studies," they say. However, since only three of the studies were performed after 1999 they acknowledge that their results may not reflect current awareness.

The researchers say that more focus is required on educating doctors about costs, and ensuring they have rapid access to cost information. For example, they say that cost information could easily be incorporated into computerised prescribing software.

They say that the level of training, speciality of the doctor and country have little impact on the results.

They say that if doctors are not aware of large price differences in medicines used for the same indication, they may continue to prescribe the more expensive drugs, especially if they are being heavily promoted (*PLoS Medicine* 2007;4:1486-96).

Hospital Pharmacist Life-long Learning winners

The winner of the *Hospital Pharmacist* Life-long Learning competition that ran from January to July/August 2007 was Katie Davies, from Cheshire. Ms Davies wins attendance at the European Association of Hospital Pharmacists annual congress, in the Netherlands in February 2008. The second prize winner is Alison Barron from County Durham who will receive registration and travel expenses for the *Hospital Pharmacist* conference in January 2008. Runners up were Rebecca Wills (Hampshire), Kevin Ashworth (Lancashire), Elizabeth Lewis (Bristol) and Jackie Price (Hertfordshire) who will receive Pharmaceutical Press vouchers or mugs.