P&MM

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Prescribing and Medicines Management

How mental health trusts are making changes to medicines management

Lin-Nam Wang reports on changes since "Talking about medicines"

In January, the Healthcare Commission published a report, "Talking about medicines", which painted a picture of neglect of medicines management in mental health trusts (MHTs) in England and Wales. For instance, one area of Kent and Medway NHS Partnership Trust has not had a specialist clinical pharmacist service for 20 years. However, there are glimmers of hope. The report acknowledged that MHTs do more to support concordance than acute trusts and it cited a dozen examples of good practice in medicines management that are in place, for example, the specialist pharmacist medicines clinic provided by a community mental health team introduced by Central and North West London Mental Health Trust. A winner at this year's Pharmaceutical care Awards (*PJ*, 7 July, p12), this clinic provides a much needed forum for patients to raise any concerns about their medicines.

Changes

It may also be worth noting that the audit on which the Healthcare Commission report is based was conducted in 2005. Although not denying that MHTs were not doing as well as they could, Graham Parton, chairman of the UK Psychiatric Pharmacy Group, told *P&MM*: "The snapshot then is not really how things are now. Things have moved on and there have been changes."

For example, since the audit, Kent and Medway has developed an in-house, region-wide protocol for recording allergies to medicines. It has also looked at improving communication at care interfaces and GPs now fax medicines records to crisis teams.

In the north, use of an audit cycle by South West Yorkshire Mental Health NHS Trust has resulted in better prescribing practices through the implementation of pharmacy prescribing guidelines, and the most recent audit shows that 86 per cent of prescriptions for antipsychotics are for monotherapy — higher than reports from other areas.

The trust has also increased pharmacy cover in the Calderdale area from 23 pharmacist hours each week, to one full-time pharmacist and 24 technician hours per week. This has enabled areas where improvements could be made to be identified and dealt with. For example, the percentage of patients receiving a medication review within 24 hours of admission or the next working day is now regularly monitored and almost at 100 per cent, and the level of incident reporting (related to medicines) has increased. "Introducing pharmacy cover has improved awareness of medicines management in ward areas. Increased incident reporting has led to improved education around medicines and the development of a medicines education training package for the trust," said Lynn Haygarth, chief pharmacist at South West Yorkshire Mental Health NHS Trust.

Other examples from across England include the approval of a pharmacist post to work with early intervention teams (pre-empting a first episode of psychosis, before hospital admission) and the setting up of patient helplines.

All this can be described as speedy progress, considering that it is only fairly recently that many MHTs began directly employing pharmacists. For example, Mr Parton's post as chief pharmacist of Avon and Wiltshire Mental Health Partnership NHS Trust is only three and a half years old. He said: "We started with a low baseline in some aspects. Acute hospitals have had a pharmacist from the year dot. My trust started having a pharmacist three and a half years ago. Before that, the trust used pharmacists through service level agreements [SLAs], but who managed those SLAs? Who reviewed them?" Mr Parton predicts that as a result of reports like "Talking about medicines" more MHTs will employ their own medicines governance expert.

In Avon and Wiltshire, some medicines management initiatives are taking pharmacists out of the dispensary, enabling them to use their knowledge and expertise in direct involvement with service users and the multidisciplinary team. "Most professionals do not have the expertise that pharmacists, who are specialists in mental health, have through either years of experience or achieving a postgraduate qualification in mental health and psychiatric therapeutics. Clearly [pharmacists] are best equipped to advise on complex medicines issues for people with severe mental illness," Mr Parton explained. For example, in 2006, a post was created in Avon and Wiltshire which requires a pharmacist to spend nearly all his time within a forensic psychiatry unit where he can ensure that a prescription is right for a service user before it reaches pharmacy. "Intervention after a prescription is written is too late," Mr Parton said.

For 18 months the trust has also had a pharmacist working with a crisis intervention team and home treatment team, which means working with psychologists, occupational therapists, psychiatrists, community psychiatric nurses and social workers. The pharmacist plays a consultative role on all issues to do with medication (eg, choice of medicine, choice of dose, timing, delivery, whether a compliance aid is needed, who will prescribe it and who will dispense it) and trains and

educates staff. "Traditionally, pharmacists were not included in these teams and mainly they are still not included. [Our pharmacist] is integrated with the team so, for example, if there was a meeting around a service user, he would be there to help develop a holistic treatment plan to include medication. [This initiative] is outstandingly effective. It fills gaps in terms of risk and governance that no one realised were there," Mr Parton said. Having a pharmacist available has improved the other professions' competence and knowledge around medicines, increased value for money and ensured that the best clinical decisions around medicines are being taken, he added.

However, such initiatives can be expensive. Mr Parton is working towards having a pharmacist member of every team but this does not mean one pharmacist per team — it is more economical to share a pharmacist's time between teams and units. "We know we are not going to get massive additional resources [to improve medicines management] but we can make things better by changing the way in which we do things," he said. "People are positive around the possibilities but there are worries around resources and the detailed planning of how we do it," he added.

One example of how MHTs are changing the way in which they work concerns SLAs. SLAs, through which MHTs commission services (eg, ward visits, medicines information and dispensing) from acute trusts, are well-known for allowing poor performance. A solution would, therefore, be to examine critically services that are performing poorly and remodel them in novel ways. New agreements could be clearer, building in key performance indicators and penalty clauses so MHTs get exactly what they want, Mr Parton explained. "We will be going out to tender shortly," he said and envisages other MHTs taking a critical look at their current services. Humber Mental Health Teaching NHS Trust has already contracted to have its dispensing undertaken by Lloydspharmacy rather than an acute trust.

Leadership

Many MHTs have taken "Talking about medicines" to heart and are working to make a difference. "Following the report, we have identified areas of particular risk and are actively seeking investment in the clinical pharmacy service at board level," Ian Maidment, senior pharmacist at Kent and Medway NHS Partnership Trust, told *P&MM*. "We have also developed business cases which will see major changes in the way clinical pharmacy services are delivered in several areas of the trust," he added.

The report summarises 10 focus areas and calls for leadership from chief pharmacists on medicines management. "A lot of the focus areas are easy to envisage. What is missing, to some degree, is a sense of leadership and direction," Mr Parton commented.

To Mr Parton, leadership means challenging status quos. It means having vision, communicating, facilitating and enabling. "A leader needs skills to argue his or her corner and has to be realistic, pragmatic and concise," he said.

"Talking about medicines" adds to wider reports on mental health, including "Delivering the Government's mental health policies: services, staffing and costs" (also published in January), and programmes for new ways of working for mental health pharmacy. "We've got these reports coming through but [improvements need] effective engagement and communication, both up and down, from the chief pharmacists to the Department of Health and the Healthcare Commission. There are a lot of initiatives happening but they are all in slight isolation. They need pulling together and co-ordinating," Mr Parton said. "The report is another pressure for the trust. What I expect to happen is that, to some extent, some of the needs that we've identified will be met. But many won't. It will be the progress of evolution rather than revolution," he added.

However, trusts are trying to make improvements in a period of uncertainty as MHTs consider becoming foundation trusts. With organisational change, some trusts may not have the capacity to take all of their chief pharmacists' recommendations on board.

Mr Parton's vision is to see specialist pharmacists associated with every community team and inpatient unit, with a clear mandate to develop strong medicines governance and practice, to empower service users, to liaise across primary and secondary care and to have an effective and efficient way of providing medicines at the point of use. "It is doable," he said.

First fellowship of FPMM announced

Peter Burrill, a specialist pharmaceutical adviser in public health at Derbyshire County Primary Care Trust, qualified as the first fellow of the Faculty of Prescribing and Medicines Management in April. "I am proud and honoured to be the first fellow of the faculty and consider it to be a rewarding personal achievement," he said.

Mr Burrill became an associate member of the faculty in 2001. Becoming a full member of the faculty involved building a portfolio of competence for assessment. This included an employment record, details of publications and conference presentations, a record of his CPD, and a key section on reflective practice. He also had to submit a detailed report on how he met the College of Pharmacy Practice's "core and supporting aspects" and the faculty's competences. As a result, Mr Burrill became a practitioner member and was granted an advanced award in 2005.

In 2006, the faculty asked Mr Burrill if he wished to be considered for assessment for fellowship — something it was offering to all members with an advanced award. Having regularly maintained his portfolio, he just needed to update his submission. Fellowship requires three competency clusters to be assessed at mastery level and three at an excellence level.

Mr Burrill provides strategic input into the prescribing and clinical effectiveness agenda locally. He is involved with the appraisal of evidence, evaluation of new drugs and guideline development. Mr Burrill said that achieving fellowship of the faculty reinforced his self-belief to practise as a specialist within his field. "I would encourage all pharmacists with an interest to consider working towards membership of the faculty," he added.

Peter Burrill: a rewarding personal achievement

Prescribing forum

The Royal Pharmaceutical Society of Great Britain, in conjunction with the Faculty of Prescribing and Medicines Management, has set up a free electronic discussion forum for pharmacist prescribers, pharmacists on prescribing courses and any person involved in implementing and supporting non-medical prescribing.

The aim is for members to be able to discuss issues and share ideas and good practice. Postings are not moderated but members are asked to keep messages positive, constructive and prescribing related. The forum can be found at http://groups.google.com/group/pharmacistprescribers and currently has over 100 members. E-mail Valerie Green (valerie.green@rpsgb.org) to join.

Patients with diabetes: problems revealed by medicines use reviews

Last year, **Nuria Laiglesia** performed over 400 medicines use reviews at Alliance pharmacies in Norwich. In this article, she shares some of her experiences of reviews with patients who have diabetes

Patients with type 2 diabetes who do not respond satisfactorily to diet and exercise after three months are prescribed oral antidiabetic drugs. A medicines use review is an ideal way to help these patients take their medicines correctly.

The dosing of most sulphonylureas is linked with breakfast or the first main meal of the day so I ask patients to tell me when they take their tablets and if they ever miss any. I also ask about their eating patterns. Patients prescribed metformin *tds*, the drug of first choice for those who are overweight, should take tablets during or after meals, corresponding to breakfast, lunch and dinner. Patients sometimes miss tablets with *tds* regimens especially if they go out for lunch or dinner.

I had one patient who had been prescribed a month's worth of metformin and did not order a repeat prescription because he thought that he only needed to take it for a month, like a course of antibiotics. An MUR also flagged up an elderly patient being prescribed glibenclamide. This presents a greater risk of hypoglycaemia so I highlighted this patient to the GP and suggested considering a shorter-acting alternative, such as gliclazide.

An MUR involves asking about side effects. For gastrointestinal disturbances with metformin, I recommend taking the tablet after food. Patients taking sulphonylureas can gain weight. If a patient has put on weight, a review at the GP practice is advisable. For some, weight gain (also a side effect of rosiglitazone) can lead to non-compliance. On one occasion, I found a patient attributing numbness in his fingers to side effects rather than linking this to diabetic neuropathy and a need to see his GP or diabetes nurse.

Insulin

In general, I have found that patients with type 1 diabetes know more about the disease than those with type 2 diabetes. For patients prescribed insulin, I find out how they use it (eg, changing injection sites). I look at basics, such as if they have any difficulties using their device and if they know how to make adjustments to diet or insulin dosage according to blood glucose readings as well as in illness, trauma or stress. One patient had readings over 10mmol/L in the mornings, and I found she was injecting her long-acting insulin with a short-acting one each morning. I referred her to her GP practice. I advise patients with

uncontrolled diabetes to record readings in a "diabetes diary" to discuss with their GP.

For patients prescribed glucagon for hypoglycaemia, I might put "check the expiry date" as an action point on the MUR form. I have noticed that many patients dependent on insulin have not heard of sharps bins.

Although lancets and test strips are not medicines, checking the patient's use of these is appropriate in an MUR. Some patients who are not on insulin believe they have to check their blood glucose every day when a once or twice weekly check should be sufficient (and would save on prescribing costs). On the other hand, I have come across patients using the same lancet for weeks, increasing their risk of infection.

For patients who use a blood glucose meter, it is worth checking that they calibrate it. Some patients do not know about control solution or where to get it so I note the telephone number for the manufacturer on their copy of the MUR form. (If a patient's meter is old, some companies also provide a new one free of charge.) Many patients who do not use insulin would like to learn how to interpret their blood glucose levels and some report that readings are an incentive to live a healthier lifestyle.

An MUR is also an opportunity to talk about over-the-counter products and their sugar content. I have found that some patients do not look at the sugar content of medicines or do not know that sugar-free versions are available.

MUR form

The MUR form is being revised by the Pharmaceutical Services Negotiating Committee and the Department of Health, and a new form is expected soon. The question "is the medicine working?" will not appear on the new form.

I usually record any advice I have given on the MUR form, even though there is no designated section. My employer provides patient information leaflets about cholesterol, blood pressure, smoking cessation and weight management, but a wider range of free leaflets is available to pharmacists in Norfolk from www.heron.nhs.uk.

A general question I ask patients is whether they have a regular diabetes check-up. I also ask about physical activity and smoking status and note possible actions for the patient on the action plan page. Diabetes is a strong risk factor for cardiovascular disease so I also check if the patient has had a CVD risk assessment. Other risk factors may necessitate the prescribing of aspirin, statins or angiotensin-converting enzyme inhibitors.

Diabetes is a complex condition. I completed a Centre for Pharmacy Postgraduate Education learning pack on the condition about three years ago and trained to measure blood glucose when I worked for Lloydspharmacy (as part of a campaign to offer free diabetes checks to every customer). However, I revised my background knowledge before starting MURs and am still learning as I go along.

Knowing how to measure blood glucose helps me talk to patients. I recommend pharmacists learn how to do so from a representative from a blood glucose machine manufacturer, a diabetes nurse or a friendly patient. On a few occasions, I have measured blood pressure during an MUR but this and measuring blood glucose are far above service requirements.

A good knowledge of the possible complications of diabetes is needed. For example, pharmacists might be asked about preventing diabetic acidosis. During one MUR, I discovered the patient had been taking co-codamol for "nerve pain" for months when tricyclic antidepressants are first choice for painful diabetic neuropathy.

Conclusion

Performing MURs has allowed me to identify problems that would have otherwise gone unnoticed. I am pleased to have the extra opportunity to ensure patients have the correct information and understanding about their medicines. I have found it helpful when colleagues have shared their experiences. I hope this article will help pharmacists with their service provision.

P&MM Prescribing and Medicines Management

From back seat passenger to driver

In February, **Alison Doherty** was one of the first pharmacists to qualify as an independent prescriber in England. She describes her first six months

The decision to become a prescriber was a natural next step in my career. Since 2003 I have worked as a medicines management pharmacist at North Somerset Primary Care Trust, which involves providing prescribing support to GP practices. This allowed me to gain an insight into how they operate and understand how a pharmacist prescriber could work symbiotically with other health care professionals, providing pharmaceutical care to patients, and the potential benefits of this.

The prescribing course at the University of Bath was part-time so I was able to continue to work full-time at the PCT and as a local pharmacy tutor for the Centre for Postgraduate Pharmacy Education. There were 11 face-to-face learning days, 14 days in the prescribing practice and additional study time. The course gave me an excellent foundation and support to begin the ongoing development of the skills and knowledge pharmacist independent prescriber (IPs) require. Guidance with more practical issues, such as professional indemnity insurance, was also given. (I am a member of the Pharmacists' Defence Association and kept it informed of my progress, both during training and on qualification.)

Now I work as an IP at Riverbank Medical Centre in Weston-super-Mare, running two clinics a week to review and manage hypertension, cardiovascular risk, minor ailments and some other long-term conditions (eg, coeliac disease). In addition, I perform medication reviews and initial health checks for new patients at the practice with any long-term condition or repeat medicines. A local agreement between the PCT and the practice allows these clinics to be provided during my PCT working hours for six months in return for the time provided by my mentor GP during my course.

My first prescription

Once I had registered as an IP with the Royal Pharmaceutical Society and completed all relevant documents for the NHS Business Services Authority, I was ready to write a prescription. I had been preparing for nearly a year and now the time had arrived. The first prescription I wrote was for felodipine 5mg tablets. During a hypertension review I established that the patient's blood pressure was not at target and a dose increase (from 2.5mg *od*) was necessary. It was all about conducting the consultation professionally, despite the nervousness and excitement I felt, as well as keeping hold of my pharmacological knowledge. I discussed the dose increase with the patient, gained his agreement, counselled appropriately, input the data to the computer and the prescription was printed. All I needed

to do was sign it, but should I sign it Alison Doherty or A Doherty? . . . My next action felt even more unusual: handing the prescription to the patient, rather than the other way around.

My next prescription initiated treatment with simvastatin for the primary prevention of coronary heart disease (following blood tests) and it has continued from there. No consultation is the same because each patient is different. The outcomes can, therefore, vary considerably and have included: providing information; collecting data (eg information relating to lifestyle factors, family history); altering current medication; prescribing a new medicine; ordering blood tests; arranging home loans of blood pressure meters; addressing issues with non-compliant and tablet-averse patients; referring to another health care professional; and arranging follow-up appointments.

Tools

Once a diagnosis has been made, pharmacist IPs are well placed to consider the need for medication, provide treatment, manage responses to treatment (adjusting treatment accordingly), provide counselling, combat side effects and address therapeutic monitoring. In my work, I follow treatment plans that I have written for long-term conditions and minor ailments. These reflect national and local prescribing guidance. Treatment plans can help provide a structure to a consultation as well as ensuring clear documentation of the consultation, both of which are important in terms of clinical responsibility and professional accountability. Treatment plans also aid follow up at future consultations, either by myself or another health care professional.

As well as treatment plans, I have found other tools developed during my training useful, for example, a patient information leaflet explaining the IP role. An aide memoire that I developed, and now use regularly when making prescribing decisions, is the mnemonic PAIN: Patient (think about age, pregnancy, ethnicity, genetics, underlying conditions); Adverse effects; Interactions; and Need. This ensures that I apply a similar thought process to each decision and, with practice, it has become second nature. My prescribing decisions so far include:

- Initiating treatment for patients who have had several raised BP readings
- Gradually stopping atenolol 50mg and starting amlodipine 5mg in a 59-year-old woman whose BP was elevated and who had a family history of diabetes
- Stopping atenolol in a 43-year-old woman who had been first prescribed it in her early thirties when she began to experience headaches and raised BP while on an oral contraceptive, which she was now no longer taking
- Monitoring and gradually decreasing valsartan from 160mg *od* in an 80-year-old on four different medicines to manage her BP when she complained of dizziness and light-headedness
- Diagnosing ACE inhibitor-induced cough and switching ramipril to candesartan
- Recognising gout as a side effect of bendroflumethiazide and suggesting it be stopped with full monitoring of BP

Pharmacist IPs can diagnose minor ailments if they feel competent to do so. For example, I have diagnosed an infected cut during a hypertension review (I prescribed flucloxacillin 250mg capsules) and otitis externa during a new patient health check (I prescribed Otomize spray).

Progress

Encouragement and support from all staff at the GP practice have played (and continue to play) a major part in the success of my new role. In the past year, I have gone from observing to partaking in and then leading patient consultations — from back seat passenger to front seat passenger, and now driver. And I am gently gaining speed as I encounter new landmarks and my confidence increases. Reflection on a daily basis helps me to recognise my strengths, address my weaknesses and know my limitations.

I have started to audit my work as an IP and I plan to use patient questionnaires so that I can further reflect on my competencies as well as market the role. This is important because I believe the role is still not fully understood by other health care professionals and, as a result, its impact and potential have yet to be fully recognised. I love the challenge that being an IP presents and highly recommend it to other pharmacists.