

# Prescribers consolidate new skills

In this third feature in a series following four pharmacists as they develop as independent prescribers, Dawn Connelly finds out how they are getting on

## Rachel Hall, a practice pharmacist who manages chronic conditions

Rachel Hall, clinical pharmacist and independent prescriber at The Old School Surgery in Fishponds, Bristol, has been consolidating her prescribing skills over the past few months. "My clinics are getting much busier and referrals are stepping up," she says. She also carries out home visits, where she undertakes medication reviews.

Ms Hall manages patients with long-term conditions and has recently finished studying a mental health module at the University of Bath. "I decided to study the mental health module after I made a clinical diagnosis of moderate depression in one of my patients," she explains. The patient did not want to be referred to a doctor so Ms Hall made the diagnosis after discussing the patient with his GP. "Doing the mental health module has not really changed the way I practise but it has made me more aware of mental health problems in patients with long-term conditions," she explains.

One problem that Ms Hall currently has is that she is having to write all of her prescriptions by hand. The company that supplies the surgery's software is not planning to upgrade its system to include a facility for pharmacist prescribers until the end of the year. "In the meantime, I am duplicating work because I have to fill in computer records as well," she

says. She is also worried that this will eventually lead to errors or omissions in the prescriptions she writes.

Ms Hall plans to set up a forum for pharmacist prescribers in Bristol, which, she says, is home to a number. She has already collated a list of prescribers in the area, including details of where they work and who funds their posts. She explains that in the past few weeks there have been two new independent prescriber posts filled, both of which are funded in part by the GP practice, rather than the primary care trust. "Today I had a GP from another practice telephone me to see if she could sit in on one of my clinics. She is thinking about employing a pharmacist independent prescriber in her surgery and was keen to see what I could do," says Ms Hall.

Ms Hall particularly enjoys the troubleshooting aspect of her prescribing role. For example, a 69-year-old man was recently referred to her by the practice nurse for a review of his medication. He was suffering from hypertension, impotence and felt like he was "drugged up all the time". He also had a history of prostate problems. He was taking seven drugs for his hypertension and prostate problems, including two alpha blockers, cyclopentiazide, an angiotensin-converting enzyme inhibitor and an an-



Rachel Hall

giotensin-II receptor antagonist. "The drugs had gradually mounted up over a number of years," explains Ms Hall. She decided to reduce his medication in several stages and at his latest review the patient's BP was much improved and his other symptoms had resolved, she says. "It took a lot of tweaking but was beneficial for the patient in the long term."

## Mahesh Sodha, a community pharmacist who runs weekly clinics



Mahesh Sodha

Mahesh Sodha, a community pharmacist in Essex, finally registered as an independent prescriber in June after delays in starting the conversion course. Mr Sodha runs weekly hypertension and chronic kidney disease

clinics at a local GP practice. "I consider myself fortunate to be working in a large modern practice that specialises in training clinicians. The practice has three accredited tutors and takes on undergraduate medical students, as well as first and second year junior doctor trainees in addition to GP registrars. Hence training me in medical examination techniques has been second nature to all the partners," he explains.

During the independent prescriber conversion course he was able to learn how to interpret ambulatory 24-hour blood pressure recordings and electrocardiograms, carry out basic examination of ears and eyes, listen to chest sounds and carry out a basic neurological examination. "I intend to go on an advanced course on ECG interpretation and would like to acquire other skills, such as assessing jugular vein pressure," he adds.

Mr Sodha has now been prescribing for three years and says that, broadly speaking, the conversion to independent status has not drastically changed his practice. "I always had an open clinical management plan that gave me some autonomy. However, I have gained a

lot of confidence and the one thing that really makes me happy is the fact that I have not had a single patient question the ability of a pharmacist to manage and prescribe for their condition."

One area in which Mr Sodha has had some success is in managing patients with stage 3 chronic kidney disease, using the recently introduced assessment of estimated glomerular filtration rate based on the US Modified Diet in Renal Disease formula.

"Although this method involves a thorough assessment of all the monitoring parameters, such as trends in levels of creatinine and urea, and whether the patient has anaemia, the therapeutic management often comes down to tight control of blood pressure and, wherever possible, use of an angiotensin-converting enzyme inhibitor," Mr Sodha explains.

Mr Sodha emphasises that he is well established as a part of the team and works closely with all clinicians. "I always have and still do seek the opinions of other clinicians when faced with complex cases. I find it boosts my confidence when fellow clinicians agree with my plan of action."

## Nicola Stoner, a hospital pharmacist who specialises in cancer care



Nicola Stoner

Pharmacist independent prescribing has really taken off at Oxford Radcliffe Hospitals NHS Trust. Nicola Stoner, consultant cancer pharmacist at the trust's Churchill Hospital, currently prescribes in the hospital's chemotherapy pre-assessment clinic but other clinics within the trust are keen to involve pharmacist prescribers.

"The trust is looking at setting up a similar clinic for haematology patients and wants a pharmacist to prescribe for that. Currently in the oncology clinics we write the inpatient medication chart and the discharge prescrip-

tion, including all patients' own medicines and chemotherapy supportive therapies," explains Dr Stoner.

An oncology outpatient chemotherapy pre-assessment clinics is also on the cards. "People see what we are doing, they like it and they want more of it," she says.

Another pharmacist within the department, Jane Gibbard, has now trained as an independent and supplementary prescriber and works along with Dr Stoner within the clinics. Dr Stoner and Miss Gibbard have developed standard operating procedures to cover their role as independent prescribers in the clinic as well as what pharmacist prescribers should write in patients' notes. This is to ensure uniformity of practice, to train other pharmacists undertaking the independent prescribing qualification and to aid non-prescribing pharmacists working in the clinic.

"We are currently auditing the service we provide, including how many patients we see, how long we spend with them, what diagnoses we make and what we prescribe. We also plan to audit all the interventions we make," Dr Stoner explains.

The audit data have yet to be analysed, however feedback from patients has been good. "Patients are pleased that their medication and symptoms are being reviewed and that we are able to spend time explaining things to them. Both the patients and the multidisciplinary team can see the benefits of introducing pharmacist independent prescribing. Anecdotally

there has been a noticeable drop in chemotherapy associated toxicities while the clinics have been running," says Dr Stoner.

In terms of challenges, Dr Stoner and Miss Gibbard find that they sometimes need to educate the multidisciplinary team about the pharmacist prescribing role. "Some doctors expect us to prescribe anything, including drugs which are outside our area of competence. We have to tell them that we have not diagnosed the problem so are not comfortable prescribing for it. Also, as pharmacist prescribers, we have to explain to the doctors that we are not legally able to prescribe Controlled Drugs, which can be a problem in this group of patients in terms of continuity of care."

Something the pharmacists have had to accept as prescribers is that colleagues may not agree with their decisions. For example, when prescribing an alternative anti-emetic regimen for patients with refractory chemotherapy-induced nausea and vomiting, there have been occasions when medical staff have subsequently changed the prescription before it was initiated. "The challenge is when you have a conflict of decision with medical staff. Nobody is wrong, it is just a different way of approaching it," explains Dr Stoner. She emphasises that having a good working relationship with the rest of the team is extremely important as an independent prescriber, especially when dealing with complex patients for whom there is more than one solution.

## Beth Hird, a primary care trust pharmacist who runs an asthma clinic

Beth Hird, a prescribing adviser at Nottinghamshire County Teaching Primary Care Trust, is enjoying her role as independent prescriber in an asthma clinic that she runs on a weekly basis at a local GP practice. However she sometimes finds it hard to juggle this with her prescribing adviser role for the PCT. "I hope that specialist pharmacist prescribing posts will be developed in the future," she says.

Mrs Hird has found that, since she gained independent prescriber status, patients expect her to be able to prescribe all their medicines for them. "This is happening much more than it did when I was working as a supplementary prescriber in the same clinic," she explains. "I now make sure I explain what I can prescribe at the start of the consultation so that patients are aware of the limitations of my role from the beginning," she adds.

Mrs Hird keeps up to date by using online news services to identify new areas of evidence around asthma, which she can then look at in more depth. In addition, she often re-reads national guidelines for the treatment of asthma. "If I am not sure about how to treat a patient I look to discuss the case with a doctor, to ensure that I continue to learn,"

she says. She also tries to attend an asthma-related training course at least once a year.

Referral to other health care professionals is not something that Mrs Hird does regularly but she has had occasion to refer patients back to their GP when she suspected that they did not have asthma.

Mrs Hird emphasises that it is important to question patients thoroughly during a consultation in order to tease out any potential problems. She relates a recent case where a 45-year-old woman presented to her clinic for a routine review claiming that her asthma was well-controlled. "On questioning, the patient was using her salbutamol inhaler on a daily basis and avoiding walking to the shops since this made her short of breath. She was taking beclomethasone 250µg, two puffs twice daily, plus salbutamol when required," says Mrs Hird. "Her inhaler technique was good," she adds.

After discussing treatment options with the patient, Mrs Hird prescribed a salmeterol inhaler, two puffs twice daily. She told the patient to continue this for four weeks and then return for a further review. "On returning to see me her symptoms had improved a little, however she was still using her salbutamol inhaler more than three times a week. While she



Beth Hird

found she could walk further than before, her activities were still limited." After further discussion it was agreed that montelukast capsules 10mg in the evening would be started. The patient is due to return to Mrs Hird's clinic in a further four weeks so that she can assess the effects of initiating the montelukast.