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Independent prescribing adds value

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February 2007 saw the first prescription written by a pharmacist independent prescriber. This freedom to act independently is both exciting and daunting at the same time. The big question is how will the profession use this new authority. Can we use independent prescribing to bring added value to patient care and will it allow us to develop the role of the pharmacist into new fields?

Many active prescribers have commented on the increased responsibility (either perceived or real) compared with their more advisory role in the past. A practitioner's skills and ability as a prescriber improve with experience and time, allowing him or her to become competent. As professionals, it is important we understand this continued development and use it as a driver for our continuing professional development.

Supplementary prescribing gives a pharmacist an introduction to the skills required for prescribing, which can then be developed as they progress to independent status. Allowing junior pharmacists to be supplementary prescribers will allow them to develop the skills required before they practise independently.

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Communication is the cornerstone of good patient care. Access to patients' medical records is essential. The use of pharmacy profiles that can be accessed only by pharmacy staff cannot be seen as being sufficient documentation. Any written communication should be in a patient's shared notes to allow continuity of care. Hospital independent prescribers should also take more responsibility for communication to a patient's GP on discharge. This may mean production of discharge summaries, improving communication of other pharmaceutical issues such as compliance problems and allergies, and counselling. It would also allow pharmacists to communicate changes to community pharmacists.

Often pharmacists will only work office hours, with limited services being provided during evenings and weekends. Patients, however, do not follow this convenient schedule. In the current climate, both in the NHS and the private sector, it is not viable to provide pharmacy services round the clock. Routine clinics are, therefore, still the obvious setting to start pharmacist prescribing services. Other patient areas will, however, greatly benefit from pharmacy input. It is often those patients with acute medical problems who have the most pharmaceutical issues. In most cases these pharmaceutical issues are not urgent and can be dealt with in a period of hours and not minutes. The important thing is regular, normally daily, review of patients' medication. The most effective way of improving pharmaceutical care and prescribing is to target the point of prescribing. On the face of it, an independent prescribing pharmacist attending a consultant ward round is not really required because there are already plenty of prescribers present. However, the presence of a pharmacist who can prescribe provides the consultant with a means to discuss therapeutic options. It allows the consultant to develop a management plan, and the pharmacist can help implement that plan. Clearly, supplementary prescribing can be used but independent prescribing allows a greater freedom. For instance, after the ward round the pharmacist can gather further information (eg, compliance and previous drug history). Using this information a far more effective treatment plan can be implemented. This again goes back to the principle of good communication and ensuring people do not get too hung up about labels for their role. These management plans can then be followed up on subsequent days to monitor and adjust treatment. This method of working allows regular review of patients with continuity of care but still remains within the current constraints of working hours.

Funding is a big issue in the current health environment. All NHS trusts are tightening their purse strings. The NHS drug budget for 2007–08 is approximately £11bn. Even a small decrease in this could make a significant impact on trust expenditure. Pharmacists have traditionally been effective at controlling drug budgets. By acting as prescribers we can further reduce drug expenditure. Effective cost saving initiatives include closer adherence to formularies, better review of expensive medicines and optimising individuals' medication. A pharmacist's extensive knowledge of side effects, indications and pharmacokinetics means we are in an ideal position to review patients' medication.

It is important that prescribing pharmacists do not just perform the menial tasks that other health care professionals do not want. An important part of junior doctors' jobs is their participation in active prescribing. They need to make decisions on choice of drug treatment. Pharmacists also need to perform their traditional clinical checking role. This allows junior doctors to learn and improve their prescribing skills. A pharmacist can, however, complement this role. Minor errors can easily be legally corrected without a junior doctor's signature. This will stop those embarrassing encounters whereby pharmacists accost doctors, drug chart in hand, over each minor error. Clearly a pharmacist can achieve far more than this. New roles will be much dependent upon situation.

At Darlington Memorial Hospital, County Durham and Darlington Foundation Trust, an effective medicines management scheme has been in place on the medical wards for a number of years. Patient-oriented medicines management means the medicine department is ideally situated to allow independent pharmacist prescribing to be introduced. All medical wards are covered by an experienced pharmacist with a postgraduate qualification, most of whom have been qualified as supplementary prescribers for a couple of years. This means they are competent and ready to begin independent prescribing. Most pharmacists work closely with a consultant allowing specialisation and good communication. Ward rounds are attended both on admission and regularly throughout patient stays. Pharmacists have been working in outpatient clinics for a number of years. This means the infrastructure for effective communication and continuity of care is already in place. Initially pharmacists will be targeting a number of areas:

- Simple medication, for example, simple analgesia, antiemetics, eye-drops — these are often low down on doctors priorities however can be important to a patient
- Dose titration — for example, optimisation of anticholinesterase inhibitors, statins and diabetic medication are often neglected after they have been initiated
- Discontinuation — for example, of medicines causing side effects, of medicines once courses are completed (this may include proton pump inhibitors and steroids, not just antibiotics)
- Continuation of patients' regular medication — for example, repeat prescribing
- Optimising therapy — for example, ensuring all secondary prevention strategies are started after myocardial infarction or a cerebrovascular accident

All this is being done in conjunction with the medical staff to ensure continuity of care, effective communication and adequate education of junior doctors while the pharmacists remain within their own competence.