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A day in the life of a supplementary prescriber

In March 2004, the first pharmacist supplementary prescriber wrote a prescription. Since then, many more pharmacists have completed their training and routinely prescribe medicines. Lorna Smalley describes her experiences as a supplementary prescriber in primary care

Lorna Smalley is medicines management pharmacist at Greater Derby Primary Care Trust and practice pharmacist at Derwent Valley Medical Practice, Derby

Supplementary prescribing enables suitably trained pharmacists and nurses to manage the care of patients with chronic diseases. If all parties agree, a prescribing partnership is formed, which allows the supplementary prescriber to take over the care of a particular patient for up to one year. Annual review allows the process to continue for a further year.

In April 2004, I completed my supplementary prescriber training and registered as a supplementary prescribing pharmacist. Since them, I have been employed one day per week at the Derwent Valley Medical Practice in Derby to develop and run hypertension clinics.

My role is incredibly varied, and has extended beyond prescribing. From answering queries regarding whether a drug is suitable for prescribing in primary care, to helping develop the practice intranet and supporting other practitioners within the practice, no two days are ever the same.

My day starts at 8.30am, when the first job is to check my pigeon hole for messages and post. I then set about answering any queries and returning any telephone calls that I have missed.

Preparation for clinic

After that I check the appointments system to see how many patients are booked in the afternoon clinic. If any new patients are booked in, I check that their care management plans have been agreed by my independent prescriber, and that the necessary entries have been made in the patient's computer record. This is essential, because without the agreement of the independent prescriber, I would be unable to write a prescription should the patient require any medicines when they come to the clinic.

If any plans have not been agreed, I contact my independent prescriber by electronic practice note to ask her to review and agree the patient's care management plan. My independent prescriber will then contact me, again by practice note, to let me know that she has agreed the plan and that prescribing can start. We have found that this method of communication, which becomes permanently attached to the patient's record, works well for us, since it reduces the need for face-to-face contact, which can be difficult in a busy practice.

Next, I check my pathology results, and act on them accordingly. Having my own pathology code means that the results of any blood tests that I have requested are sent direct to me. This means that I am able to refer any abnormal results to my independent prescriber, as required under the care plans, without increasing her workload by having to review all test results. At the moment, I have between two and four results to review per week.

My next job is to check to see if any of my patients require repeat prescriptions.

Although my patients could request their repeat prescriptions in the normal way, this would mean that a GP, who may not have seen the patient for up to a year, would sign the prescription. We believed that this was inappropriate, and at our practice, my patients' repeats are forwarded to me. At the moment, supplementary prescribers need to handwrite prescriptions because the software is still being developed to allow computer prescribing. I update the computer record and print a repeat slip for the next request. I also check to see when the patient is next due to attend clinic. As this can be up to six months since the last appointment, I attach a reminder note to the prescription if I need to see the patient before the next repeat.

New patients

Once I am happy that I am suitably prepared for the afternoon clinic, I turn my attention to inviting new patients to participate in future clinics. We have two methods of identifying potential patients.

Initially, we used computer searches to identify patients with hypertension but no other chronic diseases. This was because we wanted to target the population of stable hypertensive patients who require regular monitoring and support, and who were not attending other clinics. We wanted to provide a "one-stop shop" for these patients, which would manage their prescriptions, monitor them and review their medication. Having identified potential patients, I contact my independent prescriber for her consent.

I also receive referrals for newly diagnosed patients, and those who may have concordance issues from other members of the clinical team. Again, I contact my independent prescriber for consent.

Once I have received consent to approach the patient, I write his or her care management plan and link it electronically to their computer record. I can then send a practice note to my independent prescriber and request her agreement to be recorded in the notes. It may seem strange that we write and agree the care plan before approaching the patient because if they do not want to participate in supplementary prescribing this time will have been wasted. However, we have found that few patients do not want to participate, and this method of agreement minimises the inconvenience for the patient.

I then write to new patients with an appointment for the hypertension clinic. We usually only invite one or two new patients each week. This is because we need to ensure that there are sufficient free appointments for those requiring follow up. I also send the patient an information leaflet about supplementary prescribing. We think that it is important for our patients to understand the basis of supplementary prescribing, since they are required to give their consent.

By this point, it is usually time for lunch. This is a good opportunity to relax with the practice team, and catch up with my independent prescriber. We meet formally to discuss the clinic progress every three months, but will catch up informally most weeks. This gives me the support I need and the independence to develop as a prescriber.

Clinic

My clinics starts at 2pm. Initially, I was unsure how patients would respond to me as a prescriber since many were used to seeing me in my previous role as a community pharmacist. However, I have found that patients are just as happy to see me as they are any other member of the prescribing team. One patient, who initially came to clinic with his wife, was so impressed by the clinic that he asked to participate himself. This really boosted my confidence, and consequently I have reduced the amount of time I need to spend seeking patients' consent.

I have 20-minute appointments, which seems like a long time, but goes quickly. I am finding that balancing a concordant consulting style and running to time is much harder than I thought, and is definitely an area I need to improve. However, patients seem to appreciate the longer appointments, and I often feel I that have been able to make a real difference to their care.

For example, recently I increased the dose of a patient's angiotensin-converting enzyme inhibitor. The woman was aware that her blood pressure was higher than it should be and was keen to reduce it, although she had had previous bad experiences of adverse drug reactions. I was able to discuss side effects and allowed her the time to come to her own decision about treatment. One month later, she came to the clinic, and was thrilled to find that the increase in dose had worked.

Routine monitoring forms a large part of the consultation. One patient who I referred for a baseline electrocardiogram was diagnosed as having atrial fibrillation, and another was found to have undiagnosed diabetes following routine blood tests. Both patients are now unable to continue coming to my clinic since I am not competent in the management of their conditions. However, knowing that I have improved their long-term prognosis gives me a great deal of professional satisfaction.

After clinic

After clinic, I review the clinic and contact my independent prescriber with any areas of concern. Finally, I check my pigeon hole and e-mails and prepare to leave the surgery, another day having flown by.

Supplementary prescribing is not about replacing doctors with less expensive prescribers, nor is it a quick fix to maximise achievement of the new general medical services contract quality indicators. It is about enhancing the quality of care for patients with chronic diseases. It is time consuming, especially in the early days, as we learn how to manage time, and how to target those patients who would benefit the most. However, supplementary prescribing is a long-term investment in the future of our patients in the hope that we can prevent complications of chronic disease.

My experience of supplementary prescribing is that it is a varied and challenging role that provides a natural extension to the role of the pharmacist within the health care team. As a profession, we must grasp this opportunity to extend our prescribing role, and learn all we can from it. After all, independent prescribing is just around the corner.