

# How supplementary prescribing helps in both acute and chronic hospital care

A team of pharmacist supplementary prescribers at Southampton University Hospitals NHS Trust is proving that supplementary prescribing can be used in both acute situations on wards and chronic situations in clinics. **Clare Bellingham** reports

**F**our pharmacists at Southampton University Hospitals NHS Trust have recently started to prescribe. Three are located in Southampton General Hospital, and are prescribing in acute situations, and the fourth works at the Royal South Hants Hospital, and is prescribing in an outpatient clinic. Between them, they are demonstrating just how widely supplementary prescribing can be used.

The three pharmacists prescribing in acute care are part of the clinical nutrition team. All prescribe parenteral nutrition and one additionally prescribes a number of other drugs in intensive care. "We hope that the vast majority of patients needing parenteral nutrition will soon be managed by supplementary prescribing," says Peter Austin, senior pharmacist, nutrition support team. The idea is that the pharmacists take over the management of the patient's parenteral nutrition and that any drugs that the patient is on continue to be prescribed by doctors. "Supplementary prescribing enables us to make decisions needed on a daily basis," he says.

"Supplementary prescribing was designed for chronic conditions. We are pushing the boundaries here," says Mark Tomlin, critical care directorate pharmacist. "Patients on the intensive care unit are acutely and dramatically ill, and I am using supplementary prescribing in the unit."

Supplementary prescribing has a role, too, in the care of chronic conditions, as Annette Fitzsimons proves at an HIV clinic in the trust (see Panel).

## Clinical nutrition team

The nutrition support team consists of doctors, pharmacists, nurses and dietitians. Three of the pharmacists (there are seven altogether) have become supplementary prescribers: Mr Austin, Mr Tomlin and Peter Rhodes,

principal pharmacist, technical services. Two of the team's nurses are also training to become supplementary prescribers.

The approach taken by the hospital is to use all members of the team to the full and, as they become more and more skilled, their roles are overlapping. "The patient is under the care of the ward team. The patient is referred to the team and it is not necessarily the doctor who will see them. It could be a pharmacist, nurse or doctor," says Mr Austin.

Perhaps this explains why supplementary prescribing has been adopted so easily at the hospital: the team has worked closely together for some time. "We already had a good relationship with the medical staff and pharmacists were seen as members of the team," says Mr Austin. "The team works now because we discuss everything so we want to continue with that," adds Trevor Smith, specialist registrar in gastroenterology.

In parenteral nutrition, the skills of pharmacists in formulation, pharmaceuticals and assessing incompatibilities are key, Mr Tomlin says. This explains why pharmacists have played an important role in the nutrition team at the hospital for nearly 10 years. "In a way, we have been prescribing parenteral nutrition for all that time," he says. "We used to write the prescription out and the doctor would sign it. Whenever parenteral nutrition was initiated, pharmacist involvement was needed." Supplementary prescribing, in a sense, is a way of legalising what the pharmacists did before. "The introduction of supplementary prescribing has not been a big change to the process," says Mr Austin.

Mr Tomlin points out that under the old system, pharmacists were still liable for their decisions. He believes that if a pharmacist is 40 per cent liable for a prescription when involved in only the dispensing, then a pharmacist who has written a prescription which was signed by a doctor might be liable for as much as 80 per cent of the total. "The old system also put junior doctors in the position of having to sign prescriptions that they did not know much about," he says. Mr Austin adds: "Our posts save junior doctor hours and this is improved further with supplementary prescribing."

Medical ward rounds are conducted twice a



**Peter Austin prescribing TPN on a ward**

week on Tuesdays and Thursdays. This is when the entire clinical nutrition team, including the consultants, see patients. Non-medical ward rounds take place on Mondays, Wednesdays and Fridays. "The benefit of supplementary prescribing is that on these three days we can now make decisions and changes to patient's parenteral nutrition," explains Mr Austin. "Clinical management plans (CMPs) are agreed and reviewed on the medical ward rounds. If a new patient comes onto the ward on the other days, we either find a doctor to sign the plan or carry on under the old system until Tuesday or Thursday when the patient can be swapped onto supplementary prescribing," he says.

Since patients are on parenteral nutrition for an average of seven to 10 days, making the swap is worthwhile because it allows day-to-day adjustments to therapy to be made. "We can make these adjustments under the trust policy without supplementary prescribing but only if we confirm a change with the doctor and endorse the prescription 'prescriber contacted'. With supplementary prescribing, we can make changes immediately without the need to find a doctor," says Mr Austin.

In order to decide whether to use supplementary prescribing the following questions are asked. Does the patient need parenteral nutrition? Is supplementary prescribing appropriate? Does the patient's condition match the clinical management plan and does the whole team and patient agree? "Once it is decided, a CMP is added to their notes. It is broad enough to allow daily alterations to electrolytes," Dr Smith explains. "It was de-



**The clinical nutrition team discusses a patient's progress**

signed to enable more complicated decisions to be made," adds Mr Rhodes. The CMP has been kept as simple as possible, stating what condition is to be treated and that treatment should be according to the trust's standard protocols and guidelines.

"One of the difficulties is that unlicensed medicines are still not approved for supplementary prescribing. The bags that require a special formulation and have to be made up from scratch are unlicensed, so prescriptions for these ones have to be taken back to the doctor for a signature," Mr Tomlin explains. "This now seems exceptionally cumbersome. We need a special exemption to this rule for parenteral nutrition."

### Critical care unit

The prescription chart used in the intensive care unit has been specifically designed and contains a section for drugs with a narrow therapeutic index that require therapeutic drug monitoring (TDM). These are the drugs that Mr Tomlin prescribes in addition to parenteral nutrition. It is all about targeting the pharmacist's skills to an area that needs extra input to ensure that the drugs are managed properly.

He has two standard clinical management plans for TDM drugs. The first is for antibiotics that require TDM: vancomycin, teicoplanin, gentamicin, netilmicin, tobramycin and amikacin. The second is for other

TDM drugs and covers: digoxin for arrhythmia, phenytoin for fits, and aminophylline and theophylline for wheeze.

Both CMPs are based around monitoring the condition, interpreting the results and adjusting the dose of drug as appropriate. The patient is referred back to the independent prescriber at each consultant ward round, if the patient's condition deteriorates or there are difficulties in achieving treatment targets.

"The greatest challenge appears to be when to intervene and take over under the supplementary prescribing rules," Mr Tomlin comments. If a patient has already been started on a drug when he first assesses the notes, and the patient is likely to continue on that drug for some time, then he would take over the prescribing. But if it was shorter-term, he probably would not. Another situation in which Mr Tomlin takes over prescribing is where problems with therapy arise that require a pharmacist's input.

Taking over the prescribing of a drug that has already been started is not an ideal arrangement so Mr Tomlin ensures that he is involved in the ward round every day. "At the ward round I can identify situations where supplementary prescribing is appropriate and start it straight away," he says.

"I have had a particular issue with consent and the rules of necessity," explains Mr Tomlin. "Obtaining consent from the patient is explicit in the CMP yet my patients are un-

conscious. So I have to take the presumption of necessity." What he has done to support this decision is to test it through a patient involvement forum. Former patients were asked what they thought about pharmacists prescribing for them. "They said pharmacists are the experts and had no problem with us acting on necessity," he comments.

Marinos Elia, professor of clinical nutrition and metabolism, is happy with the introduction of supplementary prescribing. He says: "It is working well on ITU. There are areas where other professionals have more expertise than ordinary housemen on the wards. In these situations it seems reasonable to consider prescribing by these other professionals as long as their level of competence has been established."

### Meeting training needs

Julie Osborne, education and development lead for pharmacy, played a key role in the supplementary prescribers' training. She arranged their places on the courses, applied for the funding from the Workforce Development Confederation, helped the pharmacists put their portfolios together and provided other training support when it was needed. "Pharmacists thinking about undertaking the training need to be aware of the time commitment it requires. It is important to have a realistic view of that before starting," she comments.

The team has the support of chief pharmacist Martin Stephens. He comments that supplementary prescribing provides a formally, legally and professionally recognised way of using pharmacists' skills more fully. "For a chief pharmacist and for the trust board, that gives some assurance for clinical governance purposes that it is an appropriate system to use." He adds: "Supplementary prescribing uses pharmacists better, it saves junior doctor time, it provides junior doctors with a good role model for prescribing and the patient gets care from a skilled practitioner. It wins all round." But he warns: "It should be used where the pharmacist can make an additional contribution that is effective and to the benefit of the patient."

Looking to the future, Mr Stephens says that he does not expect all the pharmacists in the hospital to become supplementary prescribers because they have got other roles, too. "But I do expect it to be a more normal part of all clinical pharmacists' responsibilities."

Julia Wright, head of clinical pharmacy, says that cystic fibrosis is the next condition for which she expects a pharmacist to prescribe at the hospital. She can also see a role in cardiology. "Supplementary prescribing will only work in acute situations if the pharmacist is a key member of the team: that is fundamental to it developing," she adds.

With four prescribing pharmacists at the hospital now and another in training, Mr Stephens says that he expects the total will have reached double figures by the end of 2005. "It is exciting to be part of a team that pushes forward," he says.

## Supplementary prescribing in a clinic for HIV patients

Demonstrating that supplementary prescribing works just as well for chronic conditions is Annette Fitzsimons, lead pharmacist, HIV, at Royal South Hants Hospital, part of the Southampton University Hospitals NHS Trust. "We run medication clinics that patients with HIV come to every three to four months. They allow us to identify problems with treatment such as with adherence," she explains.

"The initial problem in introducing supplementary prescribing is getting clinical management plans set up for patients. So I will be using these clinics to target patients." Which patients are candidates will probably be agreed with doctors before the clinic starts.

The CMP that Mrs Fitzsimons uses includes the management of HIV infection with antiretrovirals, prophylaxis of opportunistic and recurrent infections, and drugs for the side effects of treatment. "My first prescription was for Combivir and nevirapine for HIV, and Septrin for pneumocystis carinii pneumonia prophylaxis," she explains.

Bringing the pharmacist's skills to the medication clinic is important in improving patient care. At the medication clinic, Mrs Fitzsimons finds out what over-the-counter medicines patients are taking, and what their GP has prescribed for them. "Some patients won't tell their GP that they are on HIV treatment if someone in their local community works in the surgery and the patient is concerned about confidentiality," she comments. "Pharmacists will automatically ask about other medicines. Doctors plan to ask but often forget."



HIV pharmacist Annette Fitzsimons

Mrs Fitzsimons comments: "It has been an exciting challenge for me to become a supplementary prescriber. I have taken time off to have a family, so I was pleased to be able to do something new and innovative." She adds that she found the reflective learning required as part of the training quite hard. "And doing an exam was a challenge after all these years," she says. But she stresses that pharmacists need to have a number of years of experience before becoming supplementary prescribers. "Experience gives you self-confidence in dealing with patients," she comments.

As for the future, she says that becoming an independent prescriber would not make a difference to the HIV treatment she can offer now. But it would mean that she could prescribe for conditions that are not included on the CMP.