

How pharmacy can benefit patients and professionals in palliative care

Harriet Adcock finds out how pharmacy's role in the palliative care of hospice patients has expanded in the past 15 years

Margaret Hook has been providing advice and medicines to St Peter's Hospice in Bristol for over 15 years. At first this was from the local community pharmacy but in 1997 the work was offered for tender and she began a 12-hour service each week, supplying drugs, discharge prescriptions and advice to the clinical team and patients. The hours have increased and, over time, as Ms Hook's clinical skills have developed and as the hospice has come to realise the value of pharmacy input, the service has expanded to cover 35 hours over four days.

Ms Hook is self-employed and is contracted to provide pharmaceutical services to the hospice. Three clinical pharmacists currently offer their services to St Peter's, which is the only hospice in the UK to have its own pharmacy that is independent of the NHS, and it is currently recruiting a fourth pharmacist to the team (see pA20).

The pharmacists at the hospice provide a full pharmaceutical assessment of patients, reviewing their medicines when they are admitted to the hospice and again after their first inpatient prescription is written.

They are also able to facilitate contact with community pharmacists, who are often the best people to answer queries about patients' treatment before their admission. "Patients with a serious illness, one that may be terminal, often stick to the same community pharmacist. It is usually more productive to contact them rather than their GP where the issue is about a drug not included on their repeat medication list because the prescribing doctor is quite likely to have been an on-call doctor," she explains.

The hospice supports patients who want to self-medicate and Ms Hook provides advice on how patients can best manage their medicines at home and at the hospice. "If patients are less fit, one of the last bits of control they have is what goes in their mouth. Some patients want that control, so we support them in that," she says.

Supplementary prescribing

Ms Hook qualified as a supplementary prescriber in 2004, having completed the prescribing course at Bath University. "It seemed a logical step to take and I could see how it would support my work," she says.

One of the biggest changes to Ms Hook's role since qualifying as a supplementary prescriber has been taking on responsibility for discharge prescriptions. And Ms Hook is keen to stress that St Peter's is not just about terminal care. "Seventy per cent of our patients

go home," she says. But in the hospice setting discharges can be unpredictable— either because a patient due to be discharged becomes too unwell to leave or because a patient suddenly wants to return home. With a pharmacist supplementary prescriber on board there is no longer a need to chase a junior doctor to sign a discharge prescription— usually the last thing on their list of priorities. "This is important because symptom control is often fine-tuned in the last 48 hours before a patient is discharged."

So how does the supplementary prescribing process work at St Peter's? Ms Hook is involved in most ward rounds, which happen twice weekly. Patients with stable disease who have been admitted to the hospice for symptom control or respite are identified since they are likely to be patients for whom supplementary prescribing is appropriate. Ms Hook then talks to the patient with medical director at St Peter's, Carol Dacombe, and introduces the idea of supplementary prescribing. "Most patients are open to the idea of a pharmacist prescribing in this way," says Ms Hook. "St Peter's is very much a multidisciplinary unit — we share information and have access to patients' records." Patients are used to a mix of professionals providing care — doctors, pharmacists, nurses, social workers, not forgetting the hospice's chaplain.

"Patients often tell their story in different ways depending on who they are talking to — a doctor, nurse or pharmacist," says Ms Hook, who is able to discuss patients' needs fully and allay fears and misapprehensions about various aspects of drug therapy. "I use the skills I learnt on the prescribing course to explain in detail what is happening in terms of a patient's condition and how certain therapies may help. In this way a patient is more likely to try the treatment being recommended to them and when they feel the benefits will have confidence in the next thing I suggest."

Recently one of the hospice's patients was admitted with fibrosing pulmonary alveolitis and who had been reluctant to try any different drugs to help relieve his symptoms. "He thanked me for spending time with him to explain in detail how each drug may help. I reviewed my intervention after the weekend and he said he had had his best night's sleep in months after using a salbutamol nebule."

She acknowledges that she is able to spend more time with patients than other prescribers working in general practice or secondary care. "At the hospice we are trying to have a real partnership with the patient. This

is the place where such a partnership works best. It's concordance in action."

As with all supplementary prescribing, the hospice uses a clinical management plan to set out the Ms Hook's prescribing responsibilities. The plan contains specific information as to what indications she can prescribe for and lists aims for the prescribing process.

The plan has not, however, limited the drugs that Ms Hook can prescribe, except for Controlled Drugs. "Because of the nature of patients receiving palliative care, many have co-existing diseases. We wanted to ensure that this did not preclude them from supplementary prescribing. My mentor is confident that I am aware of my own competencies."

Developing role

Ms Hook's role looks set to develop as further responsibilities are agreed. Proposed changes to the Misuse of Drugs Regulations made by the Home Office mean that supplementary prescribers will soon be able to prescribe CDs (see Panel), something that could bring obvious benefits to hospice patients. "This will revolutionise my prescribing and allow me fully to use my new skills. At the moment I cannot prescribe all the medication some patients need and have to ask one of our doctors to take responsibility for CD prescribing."

Dr Dacombe welcomed this news: "Margaret has, since qualifying, been able to prescribe for four fifths of her patients' needs and the hospice welcomes the extension — both the organisation and patients will benefit from her prescribing to complete a period of inpatient care and improve communication at the point of discharge."

Pharmacy's role in the palliative care of hospice patients in 2005 may be unrecognisable to some who were providing pharmaceutical services 15 years ago. By embracing the opportunities on offer to the profession, Ms Hook has helped shape a service that has brought untold benefits to patients and other professionals working in the sector.

Controlled Drugs

An amendment to the Misuse of Drugs Regulations, due to come into force on 14 March, will mean that supplementary prescribers are able to prescribe Controlled Drugs in secondary care settings. A further amendment to relevant NHS regulations will mean supplementary prescribers working in primary care can do the same from April or May.