What locums want from supervision

This fourth article on supervision has been written by Lindsey Gilpin, chairman of the English Pharmacy Board, to stimulate thinking, as part of the planned process of engagement with pharmacists, to establish a position to inform any future debate on supervision.

It is widely said that the supply of medicines cannot continue as it is. It is also said that pharmacists are best placed speaking to patients and advising on medicines and health rather than undertaking dispensing. The extended roles for pharmacists, although not so certain in today’s financial climate, are looking increasingly remote as we struggle to cope with dispensing more prescriptions.

As a locum I want a well funded, vibrant and professional network of community pharmacies. However, I also need to be confident that I can supervise the safe and effective supply of medicines and minimise risk to patients when working in them.

We all have our own line in the sand when it comes to supervision. As a locum mine is quite a way down one end. I find it difficult not to check every prescription, not just for clinical aspects but also for accuracy of the dispensing. However, in hospital practice it is quite usual for pharmacists to be entirely comfortable with technicians taking the accuracy checking role. So I asked myself why this is different and I came up with two answers. The first is that there is different legal accountability in hospital (leaving to one side this is different and I came up with two answers. The first is that there is different legal accountability in hospital (leaving to one side the responsible pharmacist Regulations) and the second is the quality of training and support that is available to technicians in hospital.

If I work with other pharmacists and I do not know them, I know the standard to which they have been trained. The same cannot be said of the other dispensary staff in community pharmacy. We have technicians, checking technicians, dispensers, checking dispensers, assistants, checking assistants, trainees of all categories and helpful assistants who have been drafted in from the bacon counter. There does not appear to be a recognised standard that any of these can be reliably said to have achieved. And the unfortunate scheme of “grandparenting” through some categories mean that there cannot be an easily accessible and robust means of understanding the competence and knowledge of dispensary staff by a locum.

Lack of confidence in system

This lack of robust standards and my lack of personal knowledge of the staff leads to a lack of confidence in the system.

When it comes to the supply of pharmacy medicines, I do not personally want to make every sale. I am happy with them being sold by a trained person on the medicines counter under a recognised procedure. However if there is any query or sale of a medicine recently switched from prescription-only to pharmacy status, I expect to be involved.

Not needing to be present while previously bagged prescriptions are given out does have an immediate appeal. However I only have to look at the number of queries that arise at the point of supply, and the possibility that patients would not come back if I was not available within a reasonable period, to realise that every person picking up a prescription should have the right of access to a pharmacist at that time. Advice as near as possible to the point of supply is my ideal.

In fact the more I think about it the more I realise that what I want is professional autonomy. I want to make my own decisions as to what constitutes the safe and effective supply of medicines. I want the systems to help me do this, but I totally accept the responsibility is my own.

The concept of remote supervision appears to be based on the idea that pharmacists should be undertaking more services and extending their clinical skills away from the pharmacy while still being responsible for everything that is happening in the pharmacy they leave behind. Certainly undertaking more services and extending clinical skills is something that I would agree with but this surely is not the way to go about it. Currently there is no shortage of pharmacists to undertake both roles. If necessary the contract should be structured to allow these services to be undertaken additionally. I participate in a thriving stop-smoking service but this is in a pharmacy where there are two pharmacists.

If I were to be carrying out other important clinical services away from the pharmacy, would my patients or I really gain from constant interruptions or queries from the staff at the pharmacy?

The danger is that you would end up doing neither job well and exposing the public to risk without any gain whatsoever. The staff back in the pharmacy would know they were interrupting you and be less likely to ask, you would not be there for advice to patients and you would be doing another important job, still worrying about what was happening elsewhere. Where on earth is the public good in this?

There is no good in trying to undertake a clinical service on the cheap. If we are going to run warfarin clinics, etc, then let us do the job properly with the appropriate level of resources.

As for the responsible pharmacist Regulations, they introduce the concept of remote supervision by allowing the pharmacist to spend short periods away from the pharmacy. If you accept that remote supervision has no place in the safe and effective running of pharmacies, then the reason for the Regulations falls away. They should be repealed forthwith.

The views expressed in this article are Mrs Gilpin’s own and do not necessarily reflect those of the Royal Pharmaceutical Society or the English Pharmacy Board.