Pharmacists and pharmacy technicians at Worthing Hospital have changed their working patterns with the development of a new clinical pharmacy service. The collaborative project worked with existing resources to create a service that could make best use of the expertise and training of staff.

Old ways of working
In the past, each pharmacist would visit one or more allocated wards daily to undertake clinical screening of prescriptions, complete medicines reconciliation and order inpatient items. The service was believed to be lacking in the following ways:

- Increasing demands on the service, such as higher patient turnover, meant that some pharmacists were struggling to handle the workload in the short time allocated to them each day.
- Some pharmacists felt that although they were making valuable interventions with regards to safe prescribing their clinical input was limited and not used to its full potential.
- The service was not making full use of the pharmacy technicians who were trained to perform advanced roles.

To try to improve the discharge process and dispensary efficiency, discharge prescriptions were being picked up by a pharmacist specifically assigned to the task and clinically screened on the ward. Despite the advantages of this ward-based discharge service — such as the availability of medical notes and being able to consult ward staff and patients with queries — the role provided little opportunity for the pharmacist to make valuable clinical contributions having not been previously involved in the patients' care.

Poor continuity was also adversely affecting the efficiency of the pharmacy service and straining the professional relationships between pharmacy and ward staff. A new approach to the delivery of the clinical pharmacy service was needed.

Planning begins
Feedback from pharmacy and nursing staff was collected using an available toolkit and the results from a survey of inpatients were reviewed. All pharmacy staff were invited to contribute to a set of brainstorming meetings to determine what the priorities of the service should be (see Box 1).

Involving pharmacists and pharmacy technicians of all grades in the development stage was important in instilling a sense of ownership for the change and ensuring a thorough understanding of how the new service would operate.

Our solution
Several clinical pharmacy teams now provide a clinical pharmacy service to a designated group of wards throughout the day. Each team consists of a lead senior pharmacist, a ward-based pharmacist (rotational band 6 or fixed band 7) and one or two pharmacy technicians (see Box 2, p334). Specialist areas, such as general intensive care and acute admissions, were not included in the change because the pharmacy service to these areas had already been optimised.

The new approach affected the roles of non-clinical pharmacists — the reallocation of ward duties to clinical pharmacy teams means these provided little opportunity for the pharmacist to make valuable clinical contributions having not been previously involved in the patients' care.

Planning begins
Feedback from staff and patients helped the development team identify key priorities of a clinical pharmacy service. These included:

- To undertake clinical screening of prescriptions to ensure the safe and effective use of medicines.
- To identify and resolve problems efficiently.
- To supply medicines in a timely manner, avoiding discharge delays and missed doses.

Box 1: Service priorities
Feedback from staff and patients helped the development team identify key priorities of a clinical pharmacy service. These included:

- To undertake clinical screening of prescriptions to ensure the safe and effective use of medicines.
- To identify and resolve problems efficiently.
- To supply medicines in a timely manner, avoiding discharge delays and missed doses.
Clinical pharmacy roles are now attached to structured development programmes and junior pharmacists gain valuable experience in a range of medical and surgical wards. The contribution from pharmacy technicians provides the opportunity for ward pharmacists to concentrate on clinical screening and monitoring.

The development of the new clinical pharmacy service at Worthing Hospital has been a welcome change. The pharmacy team believes the new model has improved the quality of the service delivered to patients and with further development will meet all the service priorities identified.

The collaborative nature of the project has inspired individuals to think about what they are doing in their roles and identify where improvements can be made. There is sense of ownership of the service among the clinical pharmacy staff and their approach to team working has strengthened.

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References

At the time of writing, Sue Ladds was associate head of pharmacy, clinical services, at Western Sussex Hospitals NHS Trust.

E: sue.ladds@uhs.nhs.uk
Antidepressant choice for patients with epilepsy

UK Medicines Information summarises the evidence for this frequently asked question:

What is the most appropriate antidepressant to use for a patient with epilepsy?

Depression is increased in people with epilepsy, with a lifetime prevalence of about 30%. Patients with epilepsy are three times more likely to be prescribed an antidepressant than the general population and twice as likely to report suicidal thoughts.

When depression is diagnosed, the first consideration should always be to check the patient’s antiepileptic regimen for potential drug-induced depression. Changing the antiepileptic to another drug with a more favourable effect on mood may be more beneficial than starting an antidepressant.

Although the risk of seizures with most antidepressants is low, before starting drug treatment patients should be made aware that there is still some degree of seizure risk.

Selective serotonin reuptake inhibitors are considered the first-line antidepressant option for patients with epilepsy. Fluoxetine is not recommended because it has a long half-life, potentially carries a greater risk of seizures and can interact with certain antiepileptics. Citalopram or sertraline are more appropriate options. They exhibit a better safety profile and have a lower likelihood of interacting with antiepileptics.

Moclobemide is a good alternative since it has a low risk of causing seizures (but should be used second line due to limited data).

Patients with epilepsy who respond poorly to, or are intolerant of, other antidepressants can be prescribed tricyclic antidepressants (TCAs) with caution, since they appear to lower the seizure threshold. If a TCA is needed, doxepin should be chosen because it is less likely to cause seizures.

Clinicians should be aware of the possibility of interactions between antidepressants and antiepileptics, and patients with epilepsy taking antidepressants should be monitored carefully.

Introducing an antidepressant gradually, starting with a low dose and not exceeding the maximum recommended dose may reduce the risk of seizures. The antidepressant should be discontinued if seizures occur or if the patient develops seizures more often.

This FAQ is taken from a “Medicines Q&A” produced by UK Medicines Information. The full document, including references, is available from www.nelm.nhs.uk (prepared September 2012).

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