A post that blends research with pharmacy practice on a hospital ward helps keep patient-safety challenges at the top of the agenda. Rachel Urban talks to Sue Laird

I spend my time out of my comfort zone

I work in a post that enables me to combine research on medicines reconciliation and a clinical role in a large teaching hospital with occasional work in community pharmacy and university teaching.

The research project focuses on threats to medicines safety that arise during transitions of care between primary and secondary care in particular. It is widely recognised that critical patient information tends to get lost here. This work will help improve systems and processes which, in turn, will improve patient safety and reduce readmission to hospital.

My career path has straddled primary and secondary care. My degree was a sandwich course at the University of Bradford, enabling me to explore hospital and community pharmacy in two six-month pre-registration placements. When I graduated I took up a post as a relief pharmacist for Moss Pharmacy, working in over 20 community pharmacies across West Yorkshire and Lancashire.

Research on repeat prescribing for my undergraduate dissertation led to my next role as clinical governance pharmacist at the former Bradford South and West Primary Care Trust (PCT). My focus was on improving the quality of clinical service delivery. In that post I developed a repeat prescribing protocol in collaboration with local GP practices and implemented enhanced services, such as a stop-smoking and emergency hormonal contraception. We also introduced pharmacist-led warfarin monitoring in primary care.

I worked with the PCT medical director, GP, Dr Matt Walsh, who was involved nationally in developing GPs with a special interest. We decided to develop this option in pharmacy which later led to the accreditation of the first pharmacists with a special interest (PhwSI) in the country. The PhwSIIs run anticoagulation monitoring in community pharmacies and GP surgeries. It was a new concept and generated a lot of interest. I was involved in implementing the new pharmacy contract in a supportive facilitative role. I ensured that community pharmacies had put in place clinical governance arrangements and provided prescribing advice to general practice and nurse prescribers.

After that I embarked on my first role as a pharmacist in a community pharmacy. The two years I spent in that post gave me experience of the day-to-day issues and pressures that community pharmacists face.

While I enjoyed that role, I did not want to stay there long term and returned to primary care as a clinical governance pharmacist, then progressed to head community pharmacy at NHS Bradford and Airedale. I had professional input into the pharmacy contract (monitoring and service development) and dealt with performance. I helped to develop pharmacists professionally to improve the way they fulfilled their contractual responsibilities.

We developed a clinical governance framework for community-based anticoagulation services plus a pharmacy-based chlamydia screening service. My current post is unusual in that I am engaged in research four days a week and work in hospital one day a week. It is a research fellowship that is jointly funded by the University of Bradford, Bradford Teaching Hospitals NHS Foundation Trust and the Bradford Institute of Health Research. I benefit from being part of a multidisciplinary research team with research supervisors from different backgrounds, including pharmacy and nursing.

Having patient contact and an opportunity to develop my clinical knowledge in hospital is great for me. In the hospital context I have greater opportunity for clinical involvement than when I was in community pharmacy. I have been allocated to an elderly medical ward, although the plan is for me to gain experience in other wards and specialties over time. The clinical role allows me to remain closer to the challenges and issues in practice.

My research is on patient safety and medicines reconciliation, looking at the issues that arise when patients transfer between different care settings and how the NHS can ensure that information on medication is transferred quickly and accurately.

This remains high on the national agenda as the National Institute for Health and Clinical Excellence and the National Patient Safety Agency have both identified the need to tackle medicines reconciliation on admission to hospital. I was attracted to the topic because I enjoy clinical governance and risk management. My work will involve a lot of multi-disciplinary working with primary and secondary care.

I will look at the roles of different people in medicines reconciliation, including the doctor, pharmacist and patient, and the systems and processes involved in where and how information is processed and communicated. That is where things tend to fall down.

Bradford has done previous work on how IT systems can be used at admission to minimise discrepancies. I hope to develop this work by looking at the impact IT systems may have at discharge. I am in the very early stages of my research and will use several research techniques to establish a current picture. Pharmacy is a great career. You have to seize every opportunity and experience as much as you can. I could not do my current job without the experience gained in previous posts. It is easy to stay with what you are used to, but I enjoy challenging myself by moving out of my comfort zone.

Rachel Urban: experience in community and hospital pharmacy prepared her for her current role

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Thinking of changing your career? This series profiles different careers in pharmacy. It is designed to provide a taster of work in different specialties. Any pharmacist who would like to contribute to the series should contact the editorial office on 020 7572 2429 or e-mail editor@pharmacy.org.uk in the first instance.