IMPLEMENTING PHARMACIST PRESCRIBING AT SCALE ACROSS A UNITED KINGDOM NHS HOSPITAL TRUST

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Background

Pharmacist prescribing is becoming embedded into secondary care clinical pharmacy.

The EQUIP study stated an 8.9% error rate with doctor prescribers in hospitals.¹

Little information on prevalence of prescribing by pharmacists or rate of errors made.

Objective

Evaluate the prevalence of prescribing by pharmacists

Quantify the rate of prescribing errors by pharmacist prescribers

Methods

Study was undertaken across three district general hospitals where pharmacists routinely prescribe on the ward.

Part 1: Prevalence of pharmacist prescribing

Prevalence of prescribing on a ward at a single point in time.

- Charts of all patients across all medical and surgical wards were assessed
- Items written by pharmacists as a proportion of all items prescribed quantified

Part 2: Prescribing Errors by Pharmacists

Prevalence of prescribing errors assessed using EQUIP Study methodology, over two weeks

- All prescribing by pharmacists across all wards was clinically assessed by other clinical pharmacists and errors documented
- · Error classification as per EQUIP study

Results

Prevalence of Pharmacist Prescribing

457 patients prescribed 5,274 items by all prescribers

Pharmacists prescribed from all but three BNF groups

Majority of prescribing was 'regular items not prescribed' (Table 1)

Pharmacists prescribed at least one item for 182 (39.8%) of patients

12.9% of all items (n=680) prescribed by a pharmacist

Table 1: Area of prescribing

Type of prescribing	prescribed (%)
Regular medication not prescribed	463(68%)
New drug	127(19%)
Correct wrongly prescribed items	51 (8%)
Item stopped	20 (3%)
Dose Change	10 (1%)
Rewritten for clarity	9 (1%)

Prescribing Errors by Pharmacists

1,413 items, prescribed by pharmacists, clinically assessed by other pharmacists

4 errors made (0.3%)

0.3% Error Rate

Error 1

Simvastatin 40mg co-prescribed with amlodipine 5mg. Maximum dose of statin restricted to 20mg when co-prescribed with calcium channel blocker

Error 2

Morphine Sulphate solution prescribed for breakthrough pain relief when the patient was taking Oxycodone liquid

Error 3

Simvastatin 40mg co-prescribed with diltiazem. Maximum dose of statin restricted to 20mg when co-prescribed with calcium channel blocker

Error 4

Prescribing not signed

Discussion/ Conclusions

Pharmacists prescribed for almost 40% of all patients across three district general hospitals, accounting for 1 in 8 of all items prescribed.

This study shows that pharmacists are active, safe and competent prescribers.

Reference

1. Dornan T, Ashcroft D, Heathfield H, et al. An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education EQUIP Study. General Medical Council. 2009. Available at: http://www.gmcuk.org/about/research/research_commissioned_4.asp [Last accessed 23/02/13]



