Development of tools for self-audit and peer review by pharmacist non-medical prescribers in non-acute settings

A novel methodology to support improved patient outcomes

Executive summary

Recent evaluations indicate that overall, nurse and pharmacist prescribing is safe and clinically appropriate. It is becoming a well-integrated and established means of managing a patient’s condition and giving him/her access to medicines. However many pharmacist prescribers practice in relative isolation from their peers and there is little or no published evidence of self-audit or peer review taking place on a regular basis. This project was established to enable selected groups of pharmacist independent prescribers (PIPs) to develop tools to enable self-audit and peer review.

Four common areas of practice for PIPs were identified as HIV, hypertension, respiratory and anticoagulation; specific self-audit tools were developed and piloted with each group. Between October 2011 and March 2012 the tools were used by a total of 20 PIPs and data were collected and examined for a total of 691 patient contacts.

Recommendations

- The self-audit tools agreed as a result of this project should be used by pharmacist prescribers to routinely review their practice.
- Peer networks should be developed and used to provide support and guidance.
- Pharmacist prescribers should build time into their practice for the purpose of self-audit and peer review. This requirement should be written into personal development plans and/or contracts of employment.
- Groups of pharmacist prescribers working in a similar area of practice could agree standards of practice and formulate similar self-audit tools which could be used to guide and develop prescribing practice.
- Pharmacist prescribers could benefit from post-qualification clinical supervision/mentoring, perhaps linking with more experienced PIPs in the same field.

Background

In 2000, the Department of Health policy objectives for the development of non-medical prescribing (NMP) were to improve patient care, choice, access and patient safety through better use of health professionals’ skills and more flexible team working across the NHS. Since 2006 pharmacists and nurses have been able to train to become independent prescribers and more recently prescribing of controlled drugs has been included.

Evidence has shown that the benefits of NMP include: faster access to medicines, more flexible patient orientated care, time-savings and improved service efficiency. NMP has been found to be safe, acceptable to both patients and to clinicians. Recent evaluations indicate that overall, nurse and pharmacist prescribing is safe and clinically appropriate. It is becoming a well-integrated and established means of managing a patient’s condition and giving him/her access to medicines.

Support has been provided for pharmacist prescribing in East and South-East England since 2003, initially through the London prescribing project and more recently by the Specialist Pharmacy Service. With the recent restructuring of the NHS and the focus on clinical commissioning, it is important that pharmacist prescribers can demonstrate to commissioners that they are able to optimally manage patients with long-term conditions. In addition, many of these practitioners are working in relative isolation and they must be able to audit and reflect on their own practice.
Aim

- To develop tools to support pharmacist independent prescribers to develop and review their practice.

Objectives

- To develop and pilot self-audit tools that would enable pharmacist independent prescribers to examine their practice in relation to agreed best practice.
- To use these tools to collect and analyse data in selected clinic settings.

Design & Methods

The project had 4 phases:
1. Recruitment of PIPs
2. Design of clinical audit tools
3. Collection of data
4. Use of data to review practice

- **Phase 1 – Recruitment of PIPs**

All chief pharmacists in provider trusts and primary care trusts in East of England, London, South Central & South East Coast regions were contacted to identify PIPs practising in non-acute settings who were responsible for managing a cohort of adult patients within a defined clinical setting, i.e. taking complete responsibility for an episode of care. Four common therapeutic areas of PIP activity were identified from the responses and PIPs working in these settings were invited to participate in the project.

- **Phase 2 – Design of clinical audit tools**

The project lead worked collaboratively with PIPs to agree a data set specific to each long-term condition, which were based on existing standards of care for the conditions being treated. The standards for the data sets were taken from national guidance where appropriate. For example NICE guidance was used for respiratory and hypertension and NPSA guidance for the management of oral anticoagulation in patients with atrial fibrillation. For the management of patients with HIV, the expert practitioners involved in the project provided guidance from their knowledge of the HIV literature.

Amendments to the audit tools were made following a two week pilot and the results were used by the PIPs to collect patient data during clinic appointments. It was agreed that the data set had to be manageable within the clinic time available. Apart from the data set used by the hypertension group, there were no existing templates on which audit data could be collected. A data set had been in use by pharmacist prescribers for patients with hypertension and this was adopted following minor amendments.

- **Phase 3– Data Collection**

The data were collected by the pharmacist practitioners for self-audit purposes and the project was advised that ethical approval was not required. Patient identifiable information was removed from the data before it was shared anonymously with the project lead. Signed permission for this sharing of data was obtained from a GP lead in each practice using an information governance (IG) form devised by the project lead (Appendix 1).

The PIPs collected prospective data over a 6 month period, except for the anti-coagulation group where PIPs chose to collect retrospective data over a 12 month period. It was agreed that all patients seen in each clinic session for the period of data collection would be included in the analysis, in order to reduce selection bias.
Phase 4 – Review of practice

Following data collection and collation by the project lead, individuals in each care group attended a meeting facilitated by the project lead, to peer review their practice. At this stage the audit tools were reviewed again and final versions produced.

Main Findings

Twenty PIPs in total collected data for the project. The four common areas of practice identified and the number of pharmacist prescribers in each group were: HIV (4), hypertension (7), respiratory (4) and anticoagulation (5). Each time a patient was seen was classed as a patient contact. Table 1 gives the breakdown by the number of contacts and the therapeutic area.

Table 1

<table>
<thead>
<tr>
<th>Therapeutic area</th>
<th>Diagnosis</th>
<th>No of patient contacts reviewed</th>
<th>Data collection period (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>HIV</td>
<td>95*</td>
<td>6</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>Hypertension</td>
<td>367</td>
<td>6</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>Asthma &amp; COPD</td>
<td>168</td>
<td>6</td>
</tr>
<tr>
<td>Anticoagulation</td>
<td>Atrial fibrillation (AF)</td>
<td>61</td>
<td>12**</td>
</tr>
</tbody>
</table>

* some patients were seen more than once  
** data collected retrospectively

Between October 2011 and March 2012 data were collected by 20 PIPs for a total of 691 patient contacts. For two groups, HIV and respiratory, pharmacists generally saw an individual patient only once during the data collection period, however the audit tool could be used on repeat visits in future and the patient outcomes examined longitudinally. For the hypertension group, the audit tool was designed to enable data collection for recurrent visits, although follow up analysis was limited to six months for this project. The anticoagulant pharmacist group were able to follow up patients for a number of visits over the 12 month period which allowed them to examine and compare their patient outcomes. Detailed analysis in each area is yet to be finalised and full reports for each group are being prepared. The final versions of the audit tools are attached in Appendix 2a-2d.

At the start of the project, there was acknowledgement by the PIPs that auditing their practice was important but they had found it difficult to prioritise. Many of the PIPs in primary care were under the additional pressure of local re-organisation. They tended to feel isolated in their practice and under pressure to justify their roles. During the group discussions facilitators observed discussion about standards of practice in which participants were reflecting on and updating their own practice in relation to that of others.

Patient assessment and recording of data was found to be manageable within the clinic time available. Within the limits imposed by self-audit, the results showed that the participants undertook a thorough assessment of patients and amended drug therapy where necessary to improve disease management in line with evidence-based, national standards.

Discussion

The process of agreeing a data set prior to data collection allowed individual practitioners to review their practice with respect to national guidance and their peers. There are few formal networks in place specifically for PIPs to share their experiences, particularly in relation to a speciality or expert area of prescribing practice. As a result PIPs can feel quite isolated, particularly those working in primary care. This peer review allowed PIPs with similar practice interests to contact each other and provide support.

Feedback from practitioners suggested that discussing the audit tools allowed the prescribers to build on their existing experience of how a consultation should be structured. It helped the PIPs to
standardise their patient consultations (as a result of agreeing the data set), thereby developing their practice during the course of the project. A similar use of the data sets would also be useful to newly qualified PIPs.

This was a self-selected group of motivated practitioners which may have led to a bias in terms of positive findings. There was an assumption that the practitioners were competent in their allocated tasks; for example that they were competent to assess patients on their inhaler technique.

In the time available for the project, it was not possible gather information on patient outcomes because most patients were only seen once. The exception was for patients managed in the anticoagulant clinics in which data were collected for a one year period retrospectively and this allowed for an assessment of patient outcome in terms of INR control and a benchmarking of practice. The patient data will be presented in more detail in four separate reports once the analysis is complete.

Further work could be done over a longer period to examine and publish patient outcomes as a result of the care provided by pharmacist prescribers. It would be useful to capture patient experience which was not included in the scope of this work.

Recommendations

- The self-audit tools agreed as a result of this project should be used by pharmacist prescribers to review their practice.
- Pharmacist prescribers should build time into their practice for the purpose of self-audit and peer review. This requirement should be written into their personal development plan and/or contract of employment
- Groups of pharmacist prescribers working in a similar area of practice should combine to agree standards of practice and formulate similar self-audit tools which could be used to guide and develop prescribing practice
- Peer networks should be developed and used to provide support and guidance.
- Pharmacist prescribers could benefit from post-qualification clinical supervision/mentoring, perhaps linking with more experienced PIPs in the same field.

Appendices

- Appendix 1 Information Governance (IG) Form
- Appendix 2a HIV Audit Tool
- Appendix 2b Hypertension Audit Tool
- Appendix 2c Respiratory Audit Tool
- Appendix 2d Anti-coagulation in Atrial Fibrillation Audit Tool

References

3. Home Office circular 009/2012 - Nurse and pharmacist independent prescribing, 'mixing of medicines', possession authorities under patient group directions and personal exemption provisions for Schedule 4 Part II drugs. 16 April 2012  
7. Personal communication, Helen Williams. September 2011.
Information Governance Form

Dear Doctor,

We are writing to you to provide information and obtain consent to take part in a clinical audit of pharmacist prescribing in primary care. The aim of the project is:

To promote and facilitate the collection of data that demonstrates the clinical effectiveness of the pharmacist practitioner

Project outline

1) Pharmacist prescribers have been identified and recruited in four therapeutic areas:

Please tick those applicable to this practice

- a. Hypertension
- b. COPD/Asthma
- c. Anticoagulation
- d. HIV

2) A data collection form has been agreed for each therapeutic area and the relevant one attached for your information.

3) The pharmacist prescriber will be collating patient data and submitting ONLY anonymised patient data on a cohort of patients, for which they have prescribing responsibilities. Patients will be numbered 1, 2, 3, 4.... No patient identifiable data will be submitted.

4) Data collection will take place between 1st October 2011 and 31st March 2012.

As I am sure you are aware the GMC states that clinical audit is essential to the provision of good care and indeed all health-care professionals have a duty to participate in clinical audit. It is particularly important for the development of pharmacist prescribers

Section 251 of the NHS Act allows patient information to be used for clinical audit without explicit patient consent, if data are anonymised. We are writing to assure you that the data will be anonymised and that the processes of this clinical audit are within the information governance framework, ensuring that handling personal information is conducted in a confidential and secure manner.

If you have any queries please contact the Lead Pharmacist Prescriber for the audit:

Print Name____________________________________
Phone number_________________________Email____________________________________

Authorisation by practice
(Please complete the details below and return to the Lead Pharmacist Prescriber)

Practice agree to participating in this clinical audit

(Name of GP Practice)

Lead Doctor for the audit –

Name: ______________________________ Signature: ______________________________

Phone number: ______________________ Email: ______________________________

Date: ______________________________