Policy, Practice and Education 2004

Limitations of the formulary and course
Cornforth P. Listen Up: We need more consistency in nurse prescribing. Nursing Times 2004; 100(44): 17.

The author of this opinion piece argues that the current formulary should be abandoned, and started again from scratch. Extended Formulary Nurse Prescribers can prescribe a wide range of medicines that patients can buy for themselves, but the list of prescription-only medicines (POMs) is very limiting, with only a few POMs that they are likely to use. The author also criticises the course, saying that it was a “typical” nursing course, with little about the practice of prescribing. (see here [1])

eReference
1. http://www.nursingtimes.net/
doi:10.1017/S1467115804002093

Minor Ailments 2004

Heartburn: H2 receptor antagonists

The first in a series of articles examining drugs or drugs groups in the extended formulary looks at the use of H2 receptor antagonists, which can be prescribed by nurse prescribers for heartburn. It lists the basic features of these drugs and then examines individual agents briefly. (see here [1])

eReference
1. http://www.nursingtimes.net/
doi:10.1017/S146711580400210X

Nurse prescribing and constipation

The costs to the NHS of constipation amount to £65 million a year, according to this article. It looks at the causes of this condition and highlights the importance of excluding underlying conditions. Lifestyle modifications, including increasing intake of fibre and fluid, form the preferred first-line approach.

Treatments with laxatives will be needed in some situations and the article discusses the different types of agents available and their use in older patients, children and people with diabetes reviewed.

doi:10.1017/S1467115804002111
Nurse prescribing in dermatology


The article looks at independent and supplementary prescribing in dermatology, using the management of acne vulgaris as an example. Independent prescribing is possible for several conditions, but the author stresses that supplementary prescribing, with its emphasis on a partnership between prescribers and patients, may have other benefits. Continuous patient support, education and advice are essential.

doi:10.1017/S1467115804002123

Impetigo treatments


The authors discuss the conclusions of their recent Cochrane review of the evidence for impetigo treatments and their implications. One was that treatment with topical antibiotics with either mupirocin or fusidic acid is at least as effective for localized impetigo as treatment with oral antibiotics and maybe more effective. Other topical antibiotics are inferior. Treatments using disinfecting agents such as chlorhexidine or povidone-iodine have hardly been studied and there is no evidence to support their therapeutic value. Impetignised eczema or atopic dermatitis should not be treated with topical antibiotics, given the evidence that prolonged use of an antibiotic in chronic conditions is important in promoting antibiotic resistance.

Final treatment choice should be guided by regional or national guidelines, as these will be informed by knowledge of local resistance patterns and may include policies to reserve some antibiotics for other more serious infections.

doi:10.1017/S1467115804002135

OTC treatments for colds and ‘flu


This article lists the characteristics of the common cold and ‘flu and discusses the over-the-counter (OTC) treatments that are available. If secondary bacterial infection is suspected, patients should be referred to a doctor.

doi:10.1017/S1467115804002147

Health Promotion 2004

Contraceptive choices


This article discusses the promotion of good sexual health, and then examines the different methods of contraception available, discussing their advantages and disadvantages.

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Minor Ailments 2004

Wound management materials


This article discusses the different types of wound management materials in common use, including: semi-permeable film dressings, amorphous hydrogels, hydrocolloids, alginates, polyurethane foam dressings, charcoal
dressings and skin protectants. It also looks at wound infection, and professional indemnity, accountability and training.

The author concludes that making a choice of dressing and justifying it can be challenging, given the increasing range of wound care products.

doi:10.1017/S1467115804002160

Policy, Practice and Education 2004

Pharmacist supplementary prescribing for chemotherapy

Andalo D. Supplementary prescribing provides a great deal of professional satisfaction. Prescribing and Medicines Management 2004; October: PM4.

A pharmacist who trained as a supplementary prescriber is now seeing patients at a chemotherapy consent clinic in West Yorkshire and prescribing treatments.

Patients visit a couple of days after diagnosis, and see an oncologist and a nurse who explain about the treatment and its possible side effects, and obtain written consent. The patient then sees the pharmacist, who takes a full drug history and ensures the patient is happy with the information given about the chemotherapy. The pharmacist works out the drug dosage and uses a standard clinical management plan which the patient signs. The treatment needs to be reviewed by the oncologist after two cycles. Before the clinic was established, there was concern about the consent process as patients were expected to give verbal consent soon after being given a diagnosis.

Preliminary feedback from staff and patients has apparently been positive. The pharmacist, Carl Booth, says that he is getting professional satisfaction from making sure that the right patient is taking the right drug at the right time, and that patients are being monitored and reviewed regularly, even though he is not actually making the decision about chemotherapy. He also says that he cannot see why he should not be making treatment decisions in the future.

doi:10.1017/S1467115804002172

Pharmacist prescribers: current experiences and what the future holds


These two articles report on the discussions and presentations about pharmacist prescribing at the recent British Pharmaceutical Conference.

The first looks at the experiences of some pharmacist supplementary prescribers, as described at the recent British Pharmaceutical Conference. One prescriber is running a smoking cessation service, one will manage a clinic in a Boots store for patients with asthma and COPD, and one has started with asthma and is planning to provide care for patients over 60 with hypertension.

Two of the pharmacists obtained access to medical records by going to the GP surgery, although one could send information to be added to the notes using an NHSnet connection. The pharmacist who will be working in Boots is planning a system of remote access for those patients for which she has CMPs. The question of whether it is cheaper to fund a nurse-run system was discussed, with the pharmacists pointing out that pharmacies are open long hours and on Saturdays.

The other article discussed the future of pharmacy prescribing. Community pharmacies in general have longer opening hours than surgeries, which should prove an advantage, and pharmacists are becoming more integrated into the healthcare team. However, access to patient records still presents a problem.
Anne Lovejoy, a lecturer in pharmacy practice from King’s College, London, commented that supplementary prescribing could be implemented more easily in the acute sector because clinics had already been working at the edge of existing legislation, but that the situation is different in primary care, with Primary Care Trusts being nervous about pharmacist supplementary prescribing. She said that of the 13 community pharmacists on the King’s course, only two have had a service funded. If supplementary prescribing is to succeed, pharmacists will have to work with other professionals, health organizations and patients.

**eReferences**

doi:10.1017/S1467115804002184

**Pharmacist prescribing in a computerised intensive care unit**


This interesting article describes the experience of introducing supplementary pharmacist prescribing in a large intensive care unit that had already introduced electronic prescribing. One of the hurdles to be overcome was the question of patient consent in this environment, which raised difficult ethical questions.

The scheme was introduced in response to the problem of decisions agreed at the ward round either not being carried out or being carried out incorrectly. The author comments that if the system were to be designed from scratch, pharmacists would be given prescribing rights, as they are the professionals with the greatest focus on drugs: the professional who ‘cared’ most about something happening would be empowered to make it happen.

In the unit, an electronic clinical information management system (CIMS) is available at each bedside to record all patient-specific monitoring, prescribing is electronic and there are plans to introduce full patient notes onto the system. The unit therefore decided to incorporate Clinical Management Plans (CMPs) onto this system.

The author then discussed the issues around informed consent. The question of how supplementary prescribing could proceed in a critical care environment was put to a Department of Health official, who responded that the defence of acting in the best interests of the patients can be used. For the unconscious patient, this is relevant because there are data showing that drug errors in the intensive care unit (ICU) are common, and the guidelines agreed are based on the best available data. Thus, supplementary prescribing can be argued to be in the best interests of the patient.

For conscious patients, the issues are different: issues such as drug dosages are not usually discussed, although consent for more elective invasive procedures such as surgery is sought. What may be considered a paternalistic approach is justified because these patients are critically ill, and under enormous stress. The decision was therefore taken that patient agreement for supplementary prescribing would not be sought unless the patient was able to communicate and psychologically stable, and this approach has been approved by the local drug and therapeutics committee. The author discussed the complex problems with this approach: does it make the patient a pawn in a professional battle for territory and are patients and their advocates being excluded from legitimate discussion. Although the approach appears reasonable, it did raise some ethical dilemmas. (see here [1])

**eReference**

doi:10.1017/S1467115804002196