SP 08 A PILOT LOOKING AT "AN ADVANCED CLINICAL INDEPENDENT PRESCRIBING PHARMACIST", MY PROSPECTIVE

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Aim To assess the impact that a Clinical Independent Prescribing Pharmacist (IPP) could have on the workload of an Emergency Department in a specialist paediatric Hospital. This is part of the Health Education West Midlands Emergency medicine pharmacy work stream.

Method This project consisted of three phases. Each phase entailed a clinical pharmacist being assigned to an Emergency Department at a different location. In order to demonstrate the viability of the role over a geographical and cultural cross section of the region, this was the site of phase II of the project.

The pilot operated for 4 weeks, working on a variable shift pattern to encompass diurnal changes in patient throughput.

Week one, time was spent in triage with nurses, who were responsible for taking observations, history and patients' presenting complaints, Then applying triage categories; green (standard), yellow (urgent), orange (immediate) assessments required.

The pharmacist would code each patient according to their perceived professional ability to manage (PAM) that patient. The categories were community pharmacy (CP), Independent prescriber (IP), Independent prescriber with additional training (IPT), Medical team (MT).

Week two, tasks in Week 1 were repeated, but in addition, the patient was followed through their entire journey and each step being documented and categorised according to their PAM categorisation.

In addition a day was spent with the emergency nurse practitioner (ENP), looking at minor injuries and a day reviewing all admissions for a 24 hour period, retrospectively assigning one of the four PAM categories.

Week 3&4, an advanced nurse practitioner (ANP), a registrar and a consultant were shadowed with the aim of gaining a better understanding of more complicated cases.

Each of the PAMs were then reviewed to assess what further training would be needed, to manage these patients.

Results Over the four week period 401 patients were observed. Of these five (1.2%) were considered to be cases that could have been managed by a CP or an IP. 24 (6%) could have been dealt

with by an IP with some input from a member of the medical team (MT). 172 (42.9%) could have been managed by an IPT, 200 (49.9%) cases required a member of the medical team (MT).

Of the 201 patients assessed who were to be managed by CP, IP, IPT, 104 (51.7%) would require additional training in minor injuries and 90 (47.3%) would have required training in clinical examination and diagnostic skills.

Conclusion The pilot was viewed positively by ED staff, including registrars. Consultants had concerns that more serious cases may not be assessed appropriately, or that the pharmacist would require too much support. In general the supervising Medical Consultant agreed with the PAMS assessments.

This pilot indicated a new role could exist for Advanced Clinical Practice qualified pharmacists in Emergency departments.