



New group will help focus on key DoH targets

The UKCPA Emergency Care Group was launched at the Spring Symposium in Birmingham.

Nicola Wake (chair) announced that the group had been developed following the success of the electronic newsgroup. Referring to recent publications by the Department of Health, she explained that pharmacists could contribute to help primary and secondary care trusts achieve key government objectives.

Opening the meeting to the floor, delegates debated the pharmacist's role on post take ward rounds, how pharmacy staff can take advantage of projects to reduce junior doctors' hours and how pharmacy can integrate into A&E departments.

The full committee are: Nicola Wake, North Tyneside; Jan Basey, Royal Liverpool; Ursula Collingon, Guy's & St Thomas'; Gail Foreshew, Queens Belfast; Dianne Gill, Antrim; Donna Gillespie, Fairfield; Caroline Goh, Mayday; Jennifer Irving, Southampton ; Anne McGettigan, Selly Oak Hospital.

If you are interested in joining, contact details are on page 5.

The deadline for contributions for the next issue is 27th August 2004.

Write to:

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Swallowing difficulties should not result in patient malnutrition

Many patients in NHS hospitals have problems with swallowing. These include patients with head and neck cancer, Parkinson's disease, stroke patients and patients with Alzheimer's disease. Ensuring these patients get appropriate calorific and nutritional intake presents difficult, but surmountable challenges for catering departments.

It is important that these patients receive a fully balanced diet. Presenting the 2004 Napp Lecture, at the May Symposium in Birmingham, Neil Palliser-Bosomworth (nutritionist with Nutricia) demonstrated how this can be achieved using normal food, thickening agents, sip feed supplements and creative culinary ability.

Pureed diets are an important method of providing

food stuffs. Ideally pureed diets should have the consistency of jelly or blanc-mange. Liquidised diets are runny and often dangerous



for patients with swallowing difficulties. Without the addition of a food thickener there is an increased risk of aspiration.

The visual aspect of pureed food can be very off putting for patients. Ensuring that pureed food retains some identity, in both col-

our and shape, can be achieved by using food thickening agents and food moulds. This can make the food more appetising to patients. This results in the number of meals being completed increasing from 6% to over 90%.

Thickening liquids, including weak tea, coffee and even beer, can help prevent dehydration.

Swallowing difficulties have significance for patients and their medicine. Most liquid medicines are formulated for children with normal swallowing.

Some companies are now making prethickened liquid medications, but these are not widely available. Speech therapists should assess for a "safe swallow" or liquid medications should be thickened.

Picture: Neil Palliser-Bosomworth from Nutricia showing off his cuisine.

IV labelling project wins safety award.

Carol Stevens (clinical pharmacy manager, Barts and the London) pictured here with Ian Hoban from Pfizer, was this years Pfizer Patient Safety Award winner.

Carol presented work on risk assessment of medicines in theatres, where they found a significant problem in the labelling of IV drugs. This has led to the managed introduction of the new labelling system at Barts and the London.



Editorial - The times they are a changin'...

There is an old Chinese blessing "May you live in interesting times". If you are a pharmacist you are surely blessed, as these are the most interesting of times

Rarely have such fundamental changes occurred in the health service. The NHS Plan, NSFs, NICE and CHI have all been in existence only a few years but are having a significant impact on the way the health service delivers care. More recently, Foundation Trusts and new financial flows will change practice even further.

In pharmacy we have had our own NHS plan - Pharmacy in the Future in 2000, A Vision for Pharmacy, and the Audit Commission Report "A spoonful of sugar" all recognising the contributions pharmacists make to patient care across all sectors.

How has pharmacy responded to all of this? If I was to judge the profession by the recent debates in the PJ I would suggest that pharmacists are more interested in self preservation than patient care. Surely now is the time for professional organisations like UKCPA to start taking a lead in terms of the benefits that pharmacists can bring to patients? Every symposium I am amazed at the number of posters and presentations demonstrating how much benefit we can bring. The time and effort that goes into these is hardly for financial gain!

What is missing is reproducibility. We have isolated pockets of expertise that rely very much on individuals' strengths and motivation. What we really need are standards of practice that ensure the excellent patient care demonstrated by some can be achieved by all. This is now becoming essential. Clinical governance means we can no longer continue to do things by trial and error, but must implement quality care in all settings.

Who is better placed to decide the expected standards of clinical pharmacy care than the Interest Groups of the UKCPA?

Duncan McRobbie
Editor

Disagree with me...? Or have something to add on this or any article email:
admin@ukcpa.com

Chair's news

To those of you who attended the Spring Symposium – I hope that you had an educational and enjoyable time. As we were fewer in number we unfortunately had to cancel the Respiratory workshop line – so apologies to the workshop presenters and to any of you who had signed up for these sessions. I hope that the Respiratory Group will present these workshops at another UKCPA study day or symposium.

Following the AGM some of the UKCPA Committee have changed – please take a moment to review the new committee on our website. I hope you will all support the committee in taking UKCPA forward.

The UKCPA is also pleased to announce the launch of the Emergency care Pharmacy group. If you have not joined any of our pharmacy groups please review our website (*and In Practice*) for the list of groups, if your particular interest is not covered let us know your ideas.

Please can I also encourage you to attend our Study days and our Symposia, as they provide a unique opportunity to share experiences, develop new ideas and network with colleagues, both formally and informally.

I look forward to meeting members, both old and new, at the Autumn Symposium.

Helena Hodges
Chair



New General Committee elected

Each year a few people give up a lot of time to make things happen at UKCPA. The General Committee of UKCPA are responsible for co-ordinating the activities of the organisation and are ably supported by a committee structure of Educational

Program, R&D, PR and the chairs of the Interest Groups.

If you would like to be a more active practice interest group member contact the Interest Group Chair. If you would consider standing as an elected member, please

contact one of the committee members or the office. Of course none of this would be possible without the continuous support of the office staff, Pat Kennedy, Dorothy Howard and Sylvia Mills, headed up by Marie Matthews.



Seen here before the Saturday dinner at the Spring Symposium, some of the 2004/5 UKCPA Committee are (L to R), Duncan McRobbie, Mike Burden (Trustee), Candy Norris, Rachel Westwood, Nicola Wake, Sally Shaw (sitting), Laurie Goldberg (Trustee), Phil Howard (Treasurer), Helena Hodges (Chair), Pat Kennedy (Office, sitting), Chris Jay, Marie Matthews (Office Manager), Graeme Hall (Professional Secretary). Missing from the picture are Chris Green, Alice Osborne, Bryony Dean-Franklin, Catherine Duggan and Sonia Sanghani (taking the photo)

Clinical Comment: Rheumatology update – the anti-tumour necrosis factor drugs. By Chris Green

In the treatment of rheumatoid arthritis, the evidence for the anti-tumour necrosis factor (anti-TNF) agents, infliximab, etanercept and adalimumab is somewhat compelling although further research is still needed.

Across the majority of the trials, it is clear that one quarter to one third of patients will not respond particularly well to these treatments and this presents a challenge to those in drug development to come up with an answer to meet these patients needs. One alternative, Anakinra, (Interleukin 1 receptor antagonist) has been the subject of an unfavourable NICE appraisal. However, other agents are in the pipeline, for example rituximab and pegylated anti-TNF antibodies, and it will be interesting to see whether these agents can meet that challenge.

Ankylosing spondylitis and psoriatic arthropathies are recently licensed indications, while unlicensed uses of these drugs are also expanding, for example, treatment of Behchet's disease and vasculitis. Thus, the patient population using these agents will continue to expand.

Distribution by homecare companies, while convenient, means that since the prescriptions are generated in secondary care, they will not routinely appear on prescribing records or repeat prescriptions in primary care.

Unless appropriate systems are in place to inform general practitioners and primary care pharmacists that their patients are using these medicines, of risks exist that important interactions, cautions or contra-indications may be overlooked when prescribing new medication for these patients. Shared care protocols may be an appropriate way forward but the complex nature and limited data on these agents may mean that non-specialists may feel uncomfortable dealing with them and thus, be at risk of overlooking them when dealing with a patient's problems. However, as medicines of this nature become increasingly common, it would be prudent to start considering other or more novel systems in order that information might be shared appropriately.

There are a number of safety concerns regarding anti-TNF agents, including reactivation or emergence of tuberculosis. Some effects may not be recognised as adverse effects of these new drugs, for example congestive cardiac failure or multiple sclerosis. Pharmacists should be alert for patients who present with possible signs of infection, since this can be life threatening in some patients. Clearly, health care professionals in primary care have a key role in identifying adverse drug reactions that may otherwise go unnoticed

until follow up clinic appointments. It is particularly important that yellow cards be completed and submitted to the CSM for these drugs. The British Society of Rheumatology, who are keeping a case register of patients using these drugs must also be informed. Furthermore, the novel nature of these medicines means that the potential for drug interactions with over the counter or herbal medicines remains unknown and pharmacists have an important role in preventing adverse drug interactions. It is important that patients know who to contact in case adverse reactions develop and in a number of cases, rheumatology units have a help line for patients, or specialist nurses who have a key role in liaising with patients.

The anti-TNF drugs have made a massive difference to patients with rheumatoid arthritis and hopefully, are here to stay. Their use is, and will continue to expand at pace, thus it is imperative healthcare providers are familiar with the issues surrounding their use. Monitoring their effectiveness and long-term outcomes is a challenge for us all.

Dr Chris Green, is Assistant Director of Pharmacy Clinical Services and the Royal Liverpool University Hospital and Chair of the UKCPA Research and Development Committee.

A warm thank you!

UKCPA would like to take this opportunity to thank all corporate members and sponsors for their support.

Therefore, a big thank you goes out to:

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- Phoenix Pharma Plc
- Sanofi-Synthelabo
- Servier Laboratories Ltd
- Sintek Ltd
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- Wyeth Laboratories

Wyeth Education and Training Award 2004

Ann-Veronica Page (Bradford University) won this years Wyeth Education and Training Award.

Research presented by Ann suggests that newly qualified pharmacists experience difficulties in interaction with other members of the healthcare team.

Junior pharmacists may benefit from role clarification and interventions which improve their communication skills.

(pictured) Ann-Veronica Page and Martin Coombes (Wyeth) at the 2004 Awards dinner.



Newsgroup addresses

If you would like to join the practice interest group electronic newsgroups, please email the group address below, giving information on your:

- Email address
- Job title
- Postal address
- Contact telephone number

UKCPA-CriticalCare-PIG-subscribe@yahoogroups.co.uk

UKCPA-EducationTraining-PIG-subscribe@yahoogroups.co.uk

UKCPA-ElderlyCare-PIG-subscribe@yahoogroups.co.uk

UKCPA-InfectionManagement-PIG-subscribe@yahoogroups.co.uk

UKCPA-PrimaryCare-PIG-subscribe@yahoogroups.co.uk

UKCPA-QualityAssurance-PIG-subscribe@yahoogroups.co.uk

UKCPA-Surgery-Theatres-PIG-subscribe@yahoogroups.co.uk

UKCPACardiologyPIG-subscribe@yahoogroups.co.uk

UKCPA-RespiratoryPIG-subscribe@yahoogroups.co.uk

UKCPA-Rheumatology-OsteoporosisPIG-subscribe@yahoogroups.co.uk

UKCPAemergencycarePI-Group-subscribe@yahoogroups.co.uk

UKCPA-DiabetesPIG-subscribe@yahoogroups.co.uk

Trial Newsgroups

The following interest group is under consideration for development into a full Group. Newsgroups are a useful way to see if this is viable. The address is:

UKCPA-PalliativeCare-ChronicPain-subscribe@yahoogroups.co.uk

If you wish to get involved in setting up either group, contact: Philip.howard27@ntlworld.com

News from the Groups

Discussions and items of interest from the interest groups.

CARE OF THE ELDERLY GROUP

PREVENTING FALLS IN OLDER PEOPLE

Two recently published systematic reviews, Chang et al¹ and a Cochrane review², have concluded that multifactorial risk assessment and management programmes are an effective method of reducing the incidence of falls in older people. Exercise programmes have shown to be effective but there is still contrasting evidence as to the benefit of modifying the home environment. Most of the trials included in the reviews were community-based, with only one trial in Chang et al and four small trials in the Cochrane review based in a hospital setting. However, a recent trial, by Haines et al³, achieved a 30% reduction in falls with an intensive multicomponent programme (an information brochure, an exercise and education programme and hip protectors) in a sub-acute hospital setting. However, it is difficult to say which of the interventions are the most effective. Overall, there has been only a modest reduction in falls (usually less than 35%) in all of these trials. Therefore, targeting patients at the greatest risk would obviously make best use of these intensive interventions.

Chang JT, et al *BMJ* 2004;328:680-3.

Gillespie Ldet al *Cochrane Database Syst Rev* 2003;4:CD000340

Haines TP, et al *BMJ* 2004;328:676-9.

PINEAPPLE IN MOUTHCARE??

We are currently debating the pro's and cons of using pineapple for mouth care on our stroke unit. We have used it in the past but our kitchens have recently been told not to supply it to the wards for fear of diabetics going hyper and teeth rotting out of people's heads! Do other units use pineapple or are most people sticking with teeth brushing and chlorhexidine? Does any one know of any research done on pineapple?

Claire Parfrey, James Paget Hospital

USEFUL WEBSITES

In light of the recent CSM warning for olanzapine and risperidone, advice on the management of older people with dementia can be found on the following websites:

<http://www.rcpsych.ac.uk/college/faculty/oap/professional/index.htm>

<http://www.rcgp.org.uk/corporate/position/drugs.asp>

<http://www.bgs.org.uk/>

AUTUMN 2004 SYMPOSIUM - BLACK-POOL

There will be three Care of the Elderly workshops at this symposium:

1. **Dementia** To review the therapeutic man-

agement of patients with Alzheimer's disease

2. **Depression** To review the therapeutic management of patients with depression

3. **Pharmaceutical Care Issues in Stroke.** To outline the important components of a pharmaceutical care plan for stroke patients

For further details please see program on web site.

Derek Taylor, Chair

EMERGENCY CARE GROUP

There have been a number of interesting questions on the Emergency Care Group discussion list over the past few months. Nigel Moloney (Southampton) raised the topic of clinical governance on Medical Admissions Units (MAUs): issues discussed included missed doses, medication not transferred from A&E to MAU and documentation (or the lack of it!) of medication administered by ambulance staff and in A&E. Patricia Duthell (St Georges, Tooting) wondered how many A&Es stocked C1 esterase inhibitor: practice varies across the country with some patients expected to keep their own stock and other A&Es keeping enough to treat all their known patients. Poor documentation by nursing staff is a common theme. Nicola Wake (Northumbria) asked the group's advice regarding implementing one stop dispensing on MAU: the resounding reply was to get base wards up and running before tackling MAU (and thank you to everybody for their helpful advice!).

Nicola Wake, Chair

INFECTION MANAGEMENT GROUP

IMG MEMBER PUBLISHED IN MAJOR JOURNAL

Congratulations to member Eleanor Woodford who has published results of her PhD entitled 'Documentation of antibiotic prescribing controls in UK NHS hospitals' in the *Journal of Antimicrobial Chemotherapy* (2004; 53: 650-). The objectives included identifying types, prevalence and nature of antibiotic prescribing control documents within NHS hospitals. Four hundred and sixty five questionnaires were sent to chief pharmacists in 2002/3 and 253 (53%) responded. One hundred and seven had a policy for antibiotic prescribing, 168 had an antibiotic formulary and 216 had guidelines on antibiotic use. All three of the above were used by 82 hospitals but 18 had no documents. Only one half of responders had annual review of documents.

The authors conclude despite apparent importance, appropriate controls for antibiotic prescribing do not exist throughout the UK.

News from the Groups cont.

UKCPA MEMBERS PRESENT AT INTERNATIONAL INFECTION CONFERENCE

Two UKCPA members recently spoke at the annual Wyeth Pharmaceuticals Hospital Infection meeting in Madrid. Kieran Hand, microbiology pharmacist at Chelsea and Westminster Hospital spoke on the role of the microbiology pharmacist and Chris Jay on surgical prophylaxis. Increasing acknowledgement of the contribution made by clinical pharmacists to good antimicrobial prescribing stewardship in hospitals was evident and led to interactive discussion. Well done to both!

NEW WEBSITE

We would like to draw your attention to the new National Electronic Library of Infection's Antibiotic Resistance website, funded by the DoH and can be found at

<http://www.antibioticresistance.org.uk>.

The National Electronic Library of Infection (<http://www.neli.org.uk>) is a Specialist Library of the National Electronic Library for Health (<http://www.nelh.nhs.uk>) aimed at health professionals in the UK.

The antibiotic site is aimed at the public and provides evidence based answers to a selection of frequently asked questions. In addition, there is an extensive database of external resources, all of which are reviewed regularly. The site highlights recent news articles in the general and medical press related to antibiotic resistance. The authors have asked that pharmacists look at the site and send your comments via the feedback form or via the website.

An online survey aims to test knowledge and attitudes to antibiotic use before and after using the website. An invite to take part should appear when you open the home page above.

DATE FOR DIARY

Reminder of the Specialist Advisory Committee on Antimicrobial Resistance and National Prescribing Centre (NPC) meeting at the RPSGB on Wednesday July 7th entitled 'Resistance is Useless' (contact NPC for information). The next UKCPA Infection Management study day is to be held on October 14th in Birmingham entitled 'Current Controversies in Infection Management.'

Wendy Lawson, for IMG committee

RESPIRATORY GROUP

NEW BTS GUIDELINES

The 2004 update to the British guideline on the management of asthma (Feb 2004) was released on 20 April. Inhaled corticosteroids should be introduced in milder cases than previously recommended, and considered for patients with any of the following:

- Exacerbation of asthma in the last two years
- Using inhaled beta-2 agonists three times a week or more
- Symptomatic three times a week or more
- Symptomatic waking one night a week

Inhaled corticosteroids are first line preventative medication in the management of asthma. The revised guideline recommends titrating inhaled corticosteroids to the lowest dose at which effective control of asthma is maintained. Long acting beta-2 agonists should not be used without a concomitant inhaled steroid.

DTB REVIEW COMBINATION INHALERS IN COPD

The Drugs and Therapeutic Bulletin (DTB March 2004) review of combination inhalers in COPD concluded that neither Seretide^R nor Symbicort^R had been compared in published trials with their individual components taken by separate inhalers.

They noted that Seretide^R improved FEV1 in severe COPD when compared with fluticasone or salmeterol given alone. Symbicort^R improved FEV1 more than budesonide alone but when compared to formoterol alone evidence was conflicting.

They found no published evidence to show Seretide^R reduced exacerbation rates more than salmeterol or fluticasone alone. Symbicort^R however had shown a reduction in exacerbation rates when compared to formoterol alone but this was not seen with budesonide.

The evidence relating to enhanced quality of life was also deemed conflicting when combination inhalers were compared to their individual components.

The DTB concluded that the use of combination inhalers first line in managing COPD is difficult to justify based on the current evidence.

This is in line with the new NICE COPD guidelines (Feb 2004) that recommend the use of a long acting bronchodilator before the introduction of an inhaled corticosteroid. The used of inhaled corticosteroids in COPD should be reserved for patients with an FEV1 less than 50% predicted.

Combination inhalers would therefore only be considered appropriate for patients established on a long acting beta-2 and an inhaled corticosteroid. Introduction of a combination inhaler could help compliance and may even reduce the cost.

As Seretide^R is currently the only MDI combination preparation available there is potential for patients to be transferred onto unnecessarily high doses of fluticasone. Inappropriate prescribing of combination inhalers i.e. too early in treatment, using high steroid doses and poor review of response to treatment continues to be of considerable concern.

Anna Murphy, Chair

Contact details for UKCPA Pharmacist groups

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Care of the Elderly: Derek Taylor
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Leadership & Management Development: Graeme Hall, tel: 0116 2587754, email: Graeme.hall@uhl-tr.nhs.uk

Rheumatology: Chris Green, tel: 0151 706 2084, email: chris.green@rlbuh.nhs.uk

Forthcoming events

September

Critical Care Group Study Day, Advancing Critical Care, Wallacepace, London, 14th September

October

Diabetes Group joint Study Day with the Yorkshire Region, New trends and treatment in Diabetes, Holiday Inn, Brighouse, West Yorkshire, 10th October

Infection Management Group Study Day, Current Controversies in Infection Management, Jury's Inn Hotel, Birmingham, 14th October

November

UKCPA Autumn Residential Symposium, Hilton Hotel, Blackpool, 21st - 23rd Nov

UKCPA/GHP Joint Conference April 2005

The UKCPA is delighted to announce the date and venue of their Joint Conference with the Guild of Healthcare Pharmacists. This meeting is being held at the Moat House Hotel, Glasgow, and will take place from the 15th—17th April 2005. Further details will be available shortly.



News from the Groups cont.

SURGERY AND THEATRES INTEREST GROUP

VASCULAR STUDY DAY

'Keeping the Circulation Going' was attended by pharmacists who had an interest in vascular surgery and the feedback from the day was excellent. A consultant from Dudley talked us through the surgical procedures which enabled us to understand an angiogram from an endarterectomy! A tissue viability nurse lecturer at Hertfordshire University discussed the management of lower limbs including vascular and arterial ulcers. In the afternoon some committee members ran a 'pearls' session covering many hot topics in vascular surgery including cilastazol, promogran, use of beta blockers in vascular surgery and nicotine replacement therapy.

SPRING SYMPOSIUM WORKSHOPS

Surgery and Theatres Group pharmacists were out in force at the Spring Symposium and the three workshops were all well attended. It was encouraging to meet both new and current members and put faces to the names we read on the email newsgroup.

The first session on Friday afternoon looked at the background of the surgical preadmission clinic (PAC) and the role of the pharmacist. This has been a regular topic for discussion on the newsgroup so it was useful to have some of the members who had already worked in a PAC. Many topics were covered including whether supplementary prescribing or patient group directions would enable pharmacists to legally write prescriptions for inpatients or discharge within the clinic. The Preoperative Association

is a recently formed organisation for healthcare professionals working in the preoperative field. We registered our disappointment that pharmacists had not been included in the Association but agreed that the ST group would write to them and register our voice!

The advice that pharmacists give to patients on stopping and restarting medicines linked into the second work shop on nil by mouth (NBM) and the management of long term medicines around surgery. Lindsay McCall, Falkirk Royal Infirmary highlighted important issues and as usual this

provoked much discussion. No consensus was reached regarding when to stop aspirin or clopidogrel nor on appropriate thromboprophylaxis regimens. Whether pharmacists were actually prescribing when they advise a patient to stop taking their medication raised another issue for us to consider.

Members of the STPG committee are compiling all NBM policies and procedures into national guidelines. If anyone is keen to help please get in touch! We are also in discussion with the Royal College of Anaesthetists about joint-working on this subject.

Rebecca White, ULCH ran the final workshop on post-operative nutrition. She covered the choice of parenteral or enteral nutrition, factors influencing this choice, and risks and patient monitoring required. Case studies highlighted particular problems such as re-feeding syndrome and how to prevent the occurrence of it. The final part of the session discussed the issues about putting medicines down feeding tubes. Did you know that Sando K turns enteral feed lumpy? Not many of the pharmacists in the workshop did either so it was very useful to see in practice. A book being written by the British Pharmaceutical Nutrition Group (BPNG) will be a useful tool for all pharmacists involved with these common queries.

All the workshops are available from the Resource Centre if you were unable to attend any of the study days, please let me know if you would like copies.

FAREWELL AND THANKS

Finally, to Chris Jay who has completed his term of office as Chairman, many thanks for his continued support to the ST committee and enthusiasm for the role of surgical and theatre pharmacists.

Rachel Westwood, Chair

CARDIOLOGY GROUP

DOSING OF LMWH IN RENAL FAILURE
Following the publication of an article in Chest (2004; 125: 856-63) some cardiology services are using of enoxparin 1mg/kg ONCE a day for patients with UA and NQWMI and compromised renal function (CrCl < 30ml/min). As this dose is not licensed in the UK, others are still converting to UFH and measuring aPTT.

CLOPIDOGREL LOADING DOSE

An article in the European Heart Journal (2004,25:476-483) suggested that 40% of patients don't achieve adequate platelet inhibition at 2.5 hours after a 300mg dose of clopidogrel.. Many units are now using 600mg of clopidogrel as a loading dose if the PCI to be performed within 4 hours.

We hope to run a study day in September, watch the newsgroup for details.

Duncan McRobbie, Chair

Caption Competition

This month we are looking for a caption for this picture of Dr Graham Davies, one of the founder members of UKCPA and Director of Clinical Studies at Brighton University..

No prizes, but we will publish some that we find amusing. Email to admin@ukcpa.com

Also send any humorous pics of UKCPA members (with their permission ideally) and we will use them in this section in the future. Digital pics only



please to the same email address. We won't say where we get them from.....!!!

Global monitoring systems for patients

A European Society of Clinical Pharmacy and American College of Clinical Pharmacy joint congress in April 2004 included sessions on multinational systems for patient safety.

Prior to marketing, new drugs may have been tested in as few as 3000 individuals. Despite rigorous clinical trial design, rare adverse drug reactions may not have been identified and post-marketing surveillance is necessary.

The WHO database of suspected adverse reactions was initiated in 1968 and 84 countries now contribute to the programme. Volvo cars are not the only safety product from Sweden: the WHO Collaborating Centre database is in Uppsala. The database holds over three million reports with 200,000 to 250,000

added annually. Drug reaction combinations standing out from background data are checked against literature and summarised by reviewers. Short summaries or 'signals' are circulated to national participating centres.

The EU drug safety monitoring centre (the European Agency for the Evaluation of Medicinal Products, EMEA) opened in London in 1995. It co-ordinates EU safety monitoring systems. Medwatch, the American Food and Drug Administration's (FDA) reporting programme, is similar.

In the UK, the National Patient Safety Agency collates error data (as opposed to adverse effects). Prof David Cousins outlined plans for drug purchasing for safety, risk assessment and development of new connectors for spinal medicines and safe practice initiatives for anticoagulants.

Alice Osborne, Principal Pharmacist, Medicines Use Research Guy's and St Thomas' Hospital

Training Pharmacists in Nutrition (TPN)

Following on from the article on page 1, **Mark Tomlin** asks why more pharmacists don't get involved in nutrition?

When I was at university we learned about protein, carbohydrates, fats and fluids. Why not apply that knowledge in the treatment of patients? Catabolic patients burn amino acids for fuel; yet we want them to build protein to have the strength to get out of hospital and recover from surgery or acute illness in the comfort of their own homes. Excess fats are bad for healthy people but at 9kCal/g you can't beat it as an isotonic source of energy in the critically ill. In parenteral nutrition it has

the advantage of being energy rich in a small volume. Pharmacists need to understand the role of carbohydrates in diabetic patients. Good blood sugar control post MI has been shown to improve outcome by 30% (1). In septic shock it improves outcome by 40% (2). This is more cost-effective than thrombolytics or activated protein C.

The unique contributions of a pharmacist (formulation knowledge, incompatibility experience and skill in managing interactions) - it's all in nutrition! Where would parenteral nutrition production be without knowledge of formulation? Choosing the most appropriate formulation for a tube fed patient can be challenging, who else but the pharmacist knows what is available. What tablets can you crush, what can you substitute to get the same therapeutic effect; these are questions for pharmacists to answer.

Who else knows about IV drug administration and the options to avoid incompatibility? Pharmacists know about calcium phos-

phate and its solubility product in parenteral nutrition. The critical aggregation number (3) can be used to predict electrolyte destabilisation of an emulsion (that is pharmaceuticals). Then there is propofol partitioned into Intralipid^R, heparin destabilisation of an emulsion, amphotericin precipitation in TPN and aciclovir or phenytoin in acidic solutions (that's pharmaceutical chemistry).

So you think there are no interactions between drugs and nutrients; you better read 'Stockley' again. What about MAOI and tyramine, neomycin and vitamin K, tetracyclines and quinolones? Oral contraceptives and vitamins A, C, B₆ and B₁₂ and folate. I guess that does not count because the pill isn't a medicine really - is it?

And then there's nutraceuticals... enteral feed can do more than just feed patients. Immune modulating feeds contain arginine; purine nucleosides and omega-3 fatty acids to enhance white blood cell function yet suppress inflammation. This has been shown to reduce length of stay, improve outcome and reduce treatment costs. Then there is the provision of micronutrients such as vitamins, minerals and trace elements. Formulating bags of potent vitamins mixtures can be a challenge, but if it gets patients out of ITU earlier that must be a good thing.

Intensive Care and Cancer patients often receive multiple antibiotics. This in turn selects out resistant organisms. Pharma-

cists should be involved in decisions to give more potent antibiotics or think laterally about alternative options. Have you been asked about treatment options for Multi-resistant Staph Aureus (MRSA), Clostridium difficile and fungal infections? Have you considered 'Yakult' or lactobacillus capsules. This is an area to explore because whilst UK references are in short supply the European literature has over 5000 references.

Liase with the dieticians about the transfer of parenteral nutrition to enteral. That's team working and it's rewarding for staff and patients. You can also manage the transfer of IV antibiotics to oral at the same time!

'But we cant prescribe it' I hear you say - Wrong. Sell some vitamins over the counter, advise on laxative selection. When you pass your supplementary prescribing exams you can prescribe this

stuff. Pharmacists working in a nutrition team have written guidelines and protocols. At Southampton we now have 3 pharmacists who are supplementary prescribers for nutrition. We cover adult patients throughout the hospital, mainly on surgical wards but also in

Intensive Care.

So who says pharmacists cant be taught to manage nutrition? Don't get me started on pharmacists and fluids!

References
1 Malmberg K. BMJ 1997; 314: 1512-5
2 Van den Berghe et al. NEJM 2001; 345: 1359-67
3 Artificial Nutrition Support in Clinical Practice by Payne-James J, Grimble G. Silk D2nd Ed published by Greenwich Medical Media Limited 2001

Mark Tomlin is ICU Pharmacist at Southampton University Hospital and Chair of UKCPA Critical Care Pharmacists group

So you think there are no interactions between drugs and nutrients.....

Who remembers to add pyridoxine to TB treatment, knows the difference between folic acid and calcium folinate and remembers to add vit B₁₂ to folic acid supplementation? The pharmacist!

Developing pharmacy practice skills in primary and secondary care

Each year a few dedicated UKCPA members give up their weekend to assist with delivering the UKCPA Pre-registration Pharmacist Intensive Weekend School. This year the event was held in Leeds from 2- 4th April 2004, and **Alice Conway** reports, yet another resounding success. Our thanks to all of them.

This intensive weekend school is aimed at developing skills necessary for screening patients for pharmaceutical care issues, creating care plans and prioritising these issues in both primary and secondary care. Mixed in with a reflective approach to professional practice and debates on key issues facing pharmacy, the interactive workshops, case studies, role play (special thank

you to Mrs McKenzie) providing the 110 attendees with an intensive weekend school in Leeds. This year the weekend coincided with the



Grand National, which together with the welcoming Leeds hospitality of the pubs and clubs enabled some relaxation for participants between workshops.

The weekend school has run for many years, enabling pre-

registration pharmacists from all sectors to mix and share their experience and practice. The balance was initially more primary care than secondary

care but over the years this has evened up.

This year's team of tutors was led by Chris Acomb, one of the original founders of the event. The team: Chris Acomb, David Alldred, Louise Cogan, Alison Eggleton, Alice Conway, Jon

Silcock, Lyn Hanning and David Webb (pictured) brought with them their experience of primary and secondary care trusts, their passion for education and development, enjoyment of teaching, expertise of the pre-registration training year, interest in the career development of potential shakers and movers of our profession - and a love of Tetley's (with the exception of Louise and Alice, both mysteriously heavily pregnant and required to map out an emergency route to the Leeds General Infirmary maternity wing).

The evaluation was exceptionally positive and has secured the weekend school in the UKCPA calendar 2004/5. For further information please contact Marie Matthews, at the UKCPA office.

Easiest "barriers" not always best to prevent harm

Understanding and implementing safer systems of work can reduce the risk to patients. **Amanda McLean** explains how this can be achieved.

We are all looking for safer systems of work and often we put in place what seems like a good preventive step, maybe following on from an incident. There are a number of ways to ensure you are putting in the RIGHT "barrier", and ways of ensuring it is will do what you are expecting it to.

Barriers can be grouped into four types:

- Human action - checking a drug dose prior to administration
- Administrative barriers – training, supervision and procedures
- Physical – protective equipment/

storage

- Natural – place time or distance

In practice, the EASIEST barriers to put in place are the human actions, but it is easy to see then why mistakes keep occurring.

Barriers can be evaluated as being strong average or weak to counter a hazard. Any barrier involving human action is marked down. Administrative barriers are only as good as their promulgation, and need to be current and constantly reinforced. Physical barriers are harder to implement as they require investment and often add in a time factor. Natural barriers can again cause delay and are therefore often overlooked as cumbersome, but if you look at the measures recommended for safer use of potassium solutions, it is the physical

separation of potassium, the requirement to treat it differently that makes the barrier effective. Recommendations for intrathecal chemo also uses "time" and separation ("place") barriers to counter the hazard.

Barrier analysis can be used retrospectively when an incident has occurred, or prospectively, as part of a risk assessment strategy. A useful tool. Have a go. More information on this from the NPSA.

Anyone interested in patient safety should look out the DoH/Design Council report – Design for Patient Safety. This is a document that is eye catching and makes a good read. Excellent graphics.

Amanda McLean is QA Pharmacist at the Western General Hospital, Edinburgh and Chair of the Quality and Risk Management Group.

UKCPA AWARDS 2004

Submissions are invited for the following awards:

hameln pharmaceutical Awards

- **Best oral presenter**
- **Best 1st time oral presentation**
- **Best poster**

Extended closing date for receipt of submissions: 30th July 04

The autumn symposium is 19th—21st Nov 04

Book early to avoid disappointment: details and registration form on the website.

Material included in *In Practice* is based on information available from resources at our disposal at the time of issue.

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