CAPA
Clinical Advisory Pharmacists Association

Newsletter – May 2016

So what do you really do??

The role of Clinical Advisory Pharmacists in primary care is expanding rapidly and we are hearing of more and more opportunities.

This has raised the question of our roles and how the different roles fit into a framework of primary care clinical advisory pharmacist services. Colleagues within our profession, and people outside our profession such as Ministry of Health, DHBs, PHOs and general practices / Health Care Homes are asking what we do and what we can do. What do we add to health outcomes?

The mission of Clinical Advisory Pharmacists is …..

To optimise medicines-related health outcomes by reducing drug-related morbidity and mortality through identifying and resolving drug therapy problems, and optimising medicines therapy.

But we are all doing this through different roles and activities.

To build up our framework, and eventual career structure, we need to identify the numerous **activities** that you all do. This is more than the roles, as defined by your work description. It is about what you **do** to fulfil those roles, and the characteristics and attributes required.

Please help us develop a clinical advisory pharmacist framework

Could you please record every activity that you do for a five day period …. Or one different day a week for five weeks? Yes – this is arduous as we have tried it … but we really need this short but intense data to develop and support our roles and work in primary care.

I have attached an example of an Activity Log that is a mixture of 2 or 3 different people's activities with some more information about the data collection. Details gathered are to highlight the range and extent of what you do, and the areas that involve decision-making based on your skills, knowledge, understanding.

When sending your activity log to linda@cpsl.biz, attach your activity log, and put your demographics in the email … where you work, title that you have, how long you have been in the role, hours worked.

What happens with all this valuable and rich data??

We will collate the results and define the different activities, clinical advisory pharmacists, and then expand to defined roles, with the expected outcomes, and the attributes required

Who will see the data

Your data will not be identifiable. It will be collated and names removed by Linda Bryant, and then the CAPA Board (Penny Clark, John Dunlop, Carolyn Woolerton, Keith Crump, Bernie McKone) will group and define the roles.

Then what ….

We will then feedback and invite discussions via audioconference to use this foundation on which to build our framework.

Questions

If you have any questions or comments please contact

Linda Bryant (linda@cpsl.biz), John Dunlop (john@cpsl.biz) and/or Penny Clark (pennyclark@extra.co.nz)

One week in the working life of ….. (Please do not circulate this log beyond our CAPA members)

The following data collection is exploring the activities undertaken by a clinical / prescribing pharmacist in general practice – **but may be clinical advisory pharmacists in many other environments**. (Important to include all roles). The aim is to record the details of each role undertaken so that we can better define the roles and attributes required for clinical advisory pharmacists.

This will assist with defining outcomes and clarifying to others what we actually 'do' and the contribution we to optimising medicines-related health outcomes. There is also a need to develop decision-making requirements and establish a career pathway as this appears to be a primary factor in proving quality clinical advisory pharmacist services

The data was collected by noting down what was involved in the roles I was doing, and then transcribing this, with more detail, into this document.

Learnings from this pilot

1. Have the piece of paper next to you so that you can note what happened in each consultation and what happened with interruptions. The form I had didn't work very well as I was scribbling more of a mind-map due to interruptions and no time to write the time etc, so was really in chunks. Post it notes can be useful.
2. Write up at the end of the day when you remember the details better as it is the details that provide more granular information. The detail is important as this will assist in providing more depth of understanding around the decision-making processes and responsibilities that are required in general practice – an area that appears to set the clinical advisory pharmacists apart and an important attribute to develop when establishing a career structure
3. **Details are important – e.g. it is not that we "counselling" a person – but what about, what depth, and what was the final decision**

Note: This was a pilot and we found that the detail/comment column requires more detail and **your** reflection on what **you** think was required for decision-making, action, and what **attribute / skill you** brought to this activity.
So your thoughts about your contribution as much as possible, please

Abbreviated *example only* of recordings

Time	Activity	Action	Detail / comment / skills
08:30	Repeat Rx*		
	Repeat	° CVD 12%, high LDL and ratio … noted to increase statin dose	Balanced age / risk
	Printer problem	° *&%$^@&%$())	
	Repeat Rx	° Rang patient to check effectiveness of new NSAID and ADRs ° Ordered CBC to track need for iron supplementation (since Aug 2015)	
	Repeat Rx	° Rang patient – checking effectiveness	Asthma inhalers
	Interruption	° Call from pharmacy. Patient discharged and changed medicines needed to be confirmed / sorted	Confirmed 1 dose change; made decision to change

		° Provided new Rx	another from tds to bd
	Interruption	° Nurse clinic – patient required Rx … discussed issues with nurse – asked to do BP, checked TSH was done (on lithium)	Checked notes as per usual repeat Rx
	Repeat Rx	° New medicines from rheumatology. Rang patient to check, confirm next blood tests; not ADRs ° Added letter re: blood type, plus 50th birthday due so organized for health health check – blood test form, plus review apt. (Also needed to be seen as she saw rheumatology frequently, but not her general practitioner for other health issues)	Was also asked what her blood type was – left letter with the Rx about this. Saw patient when she was collecting Rx and spent time explaining the heart health check, general well being (lifestyle, exercise [confirmed as possible with rheumatoid arthritis] etc)
	Clinic appointment	° Patient was referred from GP & invited in as HbA1c escalated from 85 to 110. ?reasons & make action plan. I had previously started him on lantus with good initial result. Also needed follow up re hypertension, ill-fitting stocking (vascular), retinal screening ° Shift worker (very variable) difficult with routine for sleep, medicines & meals. Lives alone, moving DHBs later in year. Diet OK. Likely progression diabetes plus lantus not optimized. Difficulty with high post prandial readings, unable to increase orals due to safety issues, doesn't want to pay for unfunded oral options. ° Agreed plan increase lantus then review with view to starting meal time insulin starting with one meal first ° BP now well controlled so no other changes ° Repeat scripts for lantus & gliclazide- didn't get enough on last script	Had to be very patient centred around difficulties with varied shift work, safety issues with taking sulphonylureas without food, discuss options to fit his lifestyle & joint decision making. Joint decision making re starting bolus insulin suits lifestyle better , less risk, targets high post prandial readings Did observations- manual BP, HR, weight
	Repeat Rx	° New outpatient clinic letter since last Rx. Checked changes ° Requested blood test to review iron supplementation; ° Reduced number of reliever inhalers on Rx	
	Repeat Rx	° Reduced the tramadol on the Rx; To see general practitioner before next Rx; have BP on collection	
	Interruption	° Walk-in patient needed consultation on how to use Colifoam ° While discussing, noted he had been told to stop his warfarin for the last week post surgery and so needed to restart this.	Was stable on 6 mg previously, for AF – so start at this dose – no loading dose
	Spirometry	° Had invited patient back … he had asthma and was poorly control. Had started the SMART protocol – and he had felt better for this, but as a 41 year old smoker, needed to check for COPD. ° Also – social issues re: housing and I had referred him to our social worker. Wanted to keep in touch ° Did spirometry (FEV_1 63% predicted). Discussion with patient as he thought it was over 50% so he had passed; wanted to do some exercise and so try again ° Explained results and COPD, plus smoking cessation (again). Showed Health Navigator site and went through this. ° Patient also commented about the 'internet things' and how he did that 'John Kirwan thing" and he was borderline for depression, but didn't believe it. ° We discussed his previous goals (a place with the ability to tend to a garden etc)	Spent time being supportive and ensuring patient knew where to go for help and support – reiterating the people at the clinic who could help him. Provided information to look at He needed time to consider what COPD meant to him – and review his symptoms in light of depression I needed to talk to our social worker re: housing, plus his general practitioner re: depression and invite in within 2 weeks
	Checked patient portal-emails	° Patient who does home INRs narrow INR range, tests weekly, e-mailed re latest result and his proposed plan for next dose, ° Noted he makes a small one off dose change with small INR change –he agreed to try less reactive approach and keep to same dose	Recently taken this on after changed GP. He prefers to test weekly Checked history of INRs and his dose changes, noted fluctuations when he adjusted dose

	Repeat Rx	° Checked renal outpatient letter ° Ordered blood test required by renal, but hadn't been done	
	Repeat Rx	° Cardiology and gastroenterology letters. ° Cardiology reduced nadolol, as noted that nadolol (gastro) seemed to be aggravating asthma. ° Tried ringing patient (land line, so no text – tried couple of times) to check on breathing / Sx but no answer. (Didn't need the nadolol Rx with other meds as gastro had Rx'd) ° Left note in records for general practitioner who was seeing patient in three days with info re: switch.	But suggested may need to trial bisoprolol – though poor evidence for gastric varices – and β-blockers reduce bleeding but not mortality
	Interruption	° Do BP for a patient to check dosage	Decision making comment … need to look over last year; looking for trends; variability etc
	Walk-in patient	° Patient had pain and wanted diclofenac which he had had previously. ° Discussion re: pain; checked renal function, GI issues, CVD – provided small amount until sees general practitioner for longer term treatment (physio etc)	Young person so decided PPI as risk mitigation not required
	Repeat Rx	° Patient walk-in - Reviewed dose for BP and HbA1c … reiterated to take metformin at 2 bd (had been meant to increase to 2 bd last time, but he had stayed at 1 bd); ° Increased dosage of BPLA ° Discussed goals (clinical in this case)	
1 pm	Lunch 30 minutes	° Discussed admissions audit by general practitioner registrar – target COPD so discussed this audit; ° Vitamin D audit by other general practitioner registrar ° And discussed pre-diabetes and the concepts of early intervention and who to target, especially as microalbuminuria may be greater than we expected in the vulnerable population	The Vitamin D audit generated a DI query / review – Vit D in eczema / respiratory tract The admissions audit indicated need for COPD audit / treatment Discussion re: new inhalers, stepwise progression and whether eosinophils relevant etc – how should we use this information in decision making for inhalers
	GP task message - Query re INR	° Referred from GP for help with INRs- Patient with valve replacement having unstable INRs, on chemo cycles, needed bridging Clexane at times, GP part time therefore input into INRs from other GPs & haematology registrars, confusing at times. INR target needed clarifying. Letters from haematology several weeks old by the time they reach the GP so unsure of current plan. GP & patient would like one person to be managing warfarin dosing. ° Phoned & e-mailed hospital oncology pharmacist colleague, cc haematologist, all agreed GP manage INR, med regimen / recent changes discussed ° Phoned & e-mailed the patient, found also recently had other medicine changes such as stopping allopurinol, she agreed to have twice a week INRs (on her GPs days of work) until chemo finished and/or 3 days after any antibiotics start- keep in touch with me via the portal if any concerns, medicine changes or usual GP away ° Clarified INR target range, highlighted in records	Took several phone calls & e-mails over a couple of days to complete Communication between patient, haematologist, oncology pharmacist & GP to establish current meds, plan re chemo, and plan to adequately monitor INR to avoid any surprises while undergoing chemo / frequent medicine changes. Also established correct INR range.
	Task message	° GP asked for opinion re medicines prior to appointment for elderly lady with hx of AF & TIAs. Recently seen by geriatrician, who recommended start back on dabigatran for AF (had been stopped in hospital 5 months previous) and start donepezil. GP also asked re plans for etidronate	Pre-work re hx & reasons meds were changed, CHA2DS2VASc and HAS BLED scores and renal function so options can be considered

			GP wished me to be at upcoming appointment to discuss with family. Decisions will probably hinge on patients and families wishes – however family need to be fully informed re stroke risk and benefits/ risks for anticoagulants so can make informed choice, also donepezil, QOL issues re medicines and also mild dementia to consider. Etidronate appears primary prevention, stable osteopenia, 10 year tx , holiday appropriate
	Clinic appointment	° Booked follow up appointment- elderly man seen by me the previous week for repeat scripts as GP was away and to review diabetes – at the appointment I had found with a random BG he was having a hypo - treated the hypo, educated re hypo treatment & not driving for 1 hour, negotiated to reduce insulin dose & asked to come back with additional readings for review, ring sooner if any more unexplained hypos – lower BG readings coincided with return to activity post foot # and I was suspicious of low overnight readings also ° At clinic discovered pattern of hypos or low readings ~ 3am – likely due to Penmix profile. Discussed options / alternate insulin regimens, most suitable at present being to continue penmix at lower dose due to lifestyle, BG profile & patients preference. Negotiated to set a new looser BG range and reduce insulin dose for safety- patient initially reluctant then agree to trial this 1 month then review ° Referred him back to the GP for a post fracture check as still sore, GP backed insulin plan up with the patient	Treatment options Education & negotiating re a suitable & agreed target BG range as he couldn't understand why his reading might be lower during the night than fasting and didn't want his fasting levels to go high-ieTargets individualized, no microalmuminuria so unlikely to progress suddenly with looser control, Collaborative- need to inform his GP whom he had known for years and had great relationship with – GP supported plan. Follow up in place
	Phone call	° Patient follow up after starting allopurinol and reducing tramadol use. Patient not taking furosemide, with no change in symptoms. Patient's wife reported run out of medication, but not sure which. Phoned again, trial medication run out. Phoned clinical trials unit to find out whether trial drug due to be finished, or not arrived. Confirmed finished. Phoned practice (7 times, no answer, plan to phone Monday). Reassured patient and his wife.	Plan to follow up allopurinol tolerance, uric acid level and any symptoms related to furosemide cessation.
	Interruption	° Hospital pharmacist rang to check a complex patients medicine history, unusual diltiazem dose written incorrectly at admission, clarified this, discussed med changes in hospital, warfarin stopped ° advised GP that the patient was admitted, plan made to follow up at discharge	
	Clinic appointment	° Patient referred from GP to discuss DEXA and decision making re bone protection. Also needed hypertension following up as had recent increase ACE inhibitor 1 month ago after 24 hour monitor. Brief follow up T1DM- ° Previous fracture, risk, scores calculated, discussed bisphosphonates benefits/ risks/ NNT, Has GORD, +/- oral or IV ? trial oral alendronate first , see if aggravates GORD as she is unsure re infusion ° Patient took information home to read & decide ° BP still elevated, had been previously checked post small dose increase GP had intended her to increase the ACE further if no ADR but she had misinterpreted	Observations- BP, HR Decision making/ literature evaluation & discussion re benefits/ risks/ NNT for bisphosphonates ° Outcome was labs were normal, she increased ACE (by 2.5mg) experienced dizziness with on dose, GP advised her to go back to the previous dose

		instructions ° Labs were due after ACE increase- advised to have these done before further increase or other options °	° She elected to get hypertension under control first before trial of bisphosphonates ° Message to GP- dizziness could have been transient - ? following up to see if she will consider trial again or other options also benefit / risk discussion
	Rx & discussed patient with GP	° I had booked 91 year old man with COPD, recently discharged from hospital, not improving post antibiotics, to see GP for review & intended to see with GP but consults overlapped. He also needed more prn salbutamol inhaler- wasn't on his medicine list or the discharge summary as he was given one salbutamol in hospital to take home, subsequently left off repeat scripts - advised GP, faxed script to the pharmacy, updated medicine list. Also discussed progress/ follow up/ "what if" plans with GP, updated & posted health plan	Liasing with the patient, pharmacy, daughter and caregiver. Refused rest home care & he and wife" hanging on" at home- social support services in place, ensuring all aware re medicines & inhalers and a "what to do if" plan
	Patient appointment	° Follow up 30 year old woman after she did not attend clinic. On warfarin for AVR and PVR and has not been attending for INR. She has run out of medication, but history shows this shouldn't be the case. Difficulty picking up medications due to financial issues. Arranged for disability allowance and helped patient fill out forms. Discuss with WINZ unsuccessfully, made referral to social worker to help. Organised blister pack of medication to keep altogether (on month free trial), and re-emphasised importance of taking meds (for heart failure) and measuring INR. Spoke with heart failure nurse specialist regarding plan, updated medication list to reflect recent changes, BP measure due to recent addition of beta blocker.	Liaison with social worker, GP, PN, CNS, WINZ, community pharmacist.
	Catch up with patient at reception	° Elderly lady previously referred from GP due to multiple long list of intolerances to BP medicines, (felt aweful, nauseaous, no energy, choking) IHD, stented 2011, elevated BP. Only on aspirin. Thinks she has never had beta blockers, other major classes trialled- extensive check of old records, discovered she had metoprolol post angiogram for ~ 2 months, stopped due to dizziness, later found to be likely due to other concurrent meds. undiagnosed asthma was suspected 1-2 years ago but not been supported by ICS & symptoms coincided with cold/ cough- GP & patient don't think she has asthma. Re beta blocker ideally bisoprolol as more cardioselective, less likely to cause bronchospasm if there is an issue but as bisoprolol is untried we had agreed to cautiously trial metoprolol first. ° Outcome: Tolerated metoprolol but mild dizziness, & had a fall in the garden, doesn't think worth persevering, seeing GP today for follow up, happy to trial bisoprolol as per plan - GP instigated low dose	Weighing up benefits and risks of treatment Choice of medicine weighed up with past suspicion of asthma- cautious trial of metoprolol first as she had tolerated it in the past whereas bisoprolol an unknown, beta blocker also useful as concurrent IHD. As caused dizziness GP & patient decided to go with plan B- small dose bisoprolol as we had previously discussed
	GP Letter	° Asked to review medication by a community nurse, patient had diarrhoea. Patient history includes IBS. Reviewed medication doses/patient age (80), medical history – on high dose atorvastatin and ezetimibe, although no history of ACS, communicated to GP and nurse referrer.	
6:00 pm	Meeting	° Discussed DHD pharmacist projects – completed and intended	

* **Repeat prescription process;**
    - Check demographics – age, gender, ethnicity
    - Identify whether this is a readily known regular / frequent patient … i.e. drug seeker, mental health, complex
    - Check classifications – drug-disease interactions; on best practice medicines for the individual in light of co-morbidities, optimized dosage; medicine still required (indication still valid)
    - Check warnings / Alerts
    - Check screening (BP, weight, electrolytes, laboratory etc)
    - Check inbox (letter from outpatients, discharge letters)
    - Recalls
    - Check medicines – frequency of prescribing; requesting all or only some medicines etc
    - Check daily record – when last seen; any new medicine changes; general practitioner's notes from last general practitioner visit; any new problems (potential clinically relevant ADRs, interactions)
    - For the prescription, would update so that the reason for the medicine was on the label e.g. 'to reduce lower pressure' etc