Independent prescribing : the podiatrist's perspective

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Life before prescribing….

“Doctor, Doctor….. Where art thou…?”

Before……

- Locally, our DF MDT clinics held in hospital with 2 podiatrists + Doctor
- Patients with acute foot complications - often requiring antibiotics for infection or urgent pain management
- If no doctor available, GP would have to be asked to prescribe – leading to delay in treatment and sometimes inappropriate prescription

Then came PGDs….

- Patient Group Directions – allow named HCPs to supply and administer named medicines within specific conditions
- Allowed some podiatrists within the DFCs to issue patients with certain antibiotics
- Limitations – no flexibility in terms of dose and duration; only applies to certain antibiotics

Benefits of prescribing

- Timely intervention – quicker access to services and medicines
- Don't have to chase Dr for prescription
- Holistic care
- Professional autonomy
- Efficient and flexible use of workforce skills

Not just about writing a prescription…

The prescribing pyramid

NPC 1999

What do I need to know as a prescriber?

- Full medical history
- Current medication (including doses and frequency)
- Including OTCs, herbal and illicit!
- Allergies / intolerances
- Does patient take their medication??
- Relevant blood test results e.g. renal status, LFTs etc.
- Patients' preferences

Safety

- *"For any given therapeutic intervention, the potential benefits of the treatment must always be balanced against the known safety concerns"*
- **ADRs account for 5% of all hospital admissions and are associated with significant morbidity and mortality risks**
- **Individual prescriber carries the responsibility for any prescription**

Things I considered…

- How often would I be likely to prescribe?
- Would it enhance the care provided for my patients?
- How would my patients benefit?
- Had I got the necessary support?
- Was I prepared to accept the responsibility for prescribing decisions?

What have I learnt?

- Always question the need for a prescription – *do they really need more antibiotics?*
- Consider the patient – what is best for them?
- Things go wrong! *Can't always predict effects – but can mitigate*
- You need time to think and concentrate
- That I can STOP medicines!
- The "buck" really does stop with me
- Prescribing is a huge responsibility
- Not all doctors are good prescribers!
- Check blood results / interactions
- Communication essential

What have I learnt?

- Patients like to be told why they need their medicine and how they should take it
- Medical colleagues very supportive – *and I think have learnt a bit!*
- *Record, Review, Reflect*
- I have the potential to kill someone
- More cost aware
- Patients happy to receive the medicines from AHPs

June 2010 – May 2014

- **1,445 prescriptions**
- **3 yellow cards for significant adverse reactions**
- **Average of just over 1 prescription per clinic**
- **No complaints**
- **All patients asked for consent – no refusals**
- **GP letter for every activity**
- **Many “non-prescribing” interventions**
- **Increased knowledge of colleagues**

Aims of non-medical prescribing

- **To make more effective use of the skills and expertise of groups of professions**
- **To improve patients' access to treatment and advice**
- **To improve patient choice and convenience**
- **To contribute to more flexible team working across the NHS**

NPC 1999

Mrs P

- **84 years old – lives alone**
- **Neuroischaemic foot ulcer – superficial, no infection – almost healed**
- **T2 DM – HbA1c 48mmol/mol (6.5%)**
- **Gliclazide 80mg bd**
- **GP diabetes review – “excellent control”**

Mrs P

- GFR 38 (CKD stage 3B) 6/12 ago
- Asked about hypoglycaemia
- No BGM
- “I often feel a bit sweaty and dizzy especially in the morning and late afternoons – probably just my age”
- BG in clinic (10.30am) 3.8mmol/l

Action

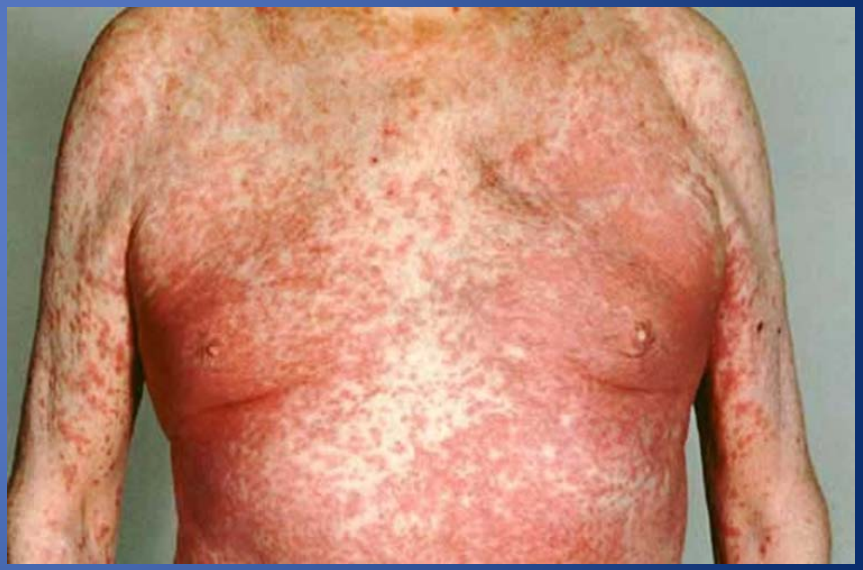
- Discussed hypoglycaemia and associated risks
- Advised to reduce Glicalzide to 40mg om
- Introduced to DSN - Given BGM and shown how to use
- To test twice a day (before breakfast and dinner)
- DSN to phone patient in 1/52
- Pt given DSN phone number
- Letter to GP / district nurses
- Repeat renal bloods
- Repeat HbA1c 2-3/12

Mr C

- T2 DM 20+ years
- CKD stage 5 – on dialysis
- Foot ulcer / infection
- On Clindamycin 450mg qds
- Osteomyelitis on x-ray
- Ciprofloxacin 500mg od added in
- ‘Standard’ advice given to patient
- No known allergies

1 week later

- Patient stopped Ciprofloxacin
- Severe itching – given anti-histamine by GP
- Resolved when drug stopped
- Yellow card completed
- Allergy status updated



Generalised fixed drug eruption

The podiatrist's perspective…

- We're not doctors!
- Awareness of limitations
- Compliments existing MDT
- Using skills and experience
- Importance of critical reflection – ongoing learning
- Can free up specialist medical staff – but not replace
- Enhanced knowledge

The podiatrist's perspective….

- Podiatrists with the right experience and expertise are well placed to meet the challenge
- Safe – NMPs acutely aware of the risks and responsibilities
- Huge increase in responsibility and risk
- Development of professional role
- Enhanced professional standing

Not just about the prescription

Just because we CAN prescribe, doesn't mean we have to!