Independent prescribing: the podiatrist’s perspective

Debbie Sharman
Consultant Podiatrist – Diabetes
Dorset HealthCare University Foundation Trust
Visiting Lecturer
University of Southampton

Debbie.sharman@dhuft.nhs.uk

@Debbiesharman
Life before prescribing....

“Doctor, Doctor..... Where art thou...?”
• 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
"Pick something you can tolerate from this list of side effects and I'll prescribe something appropriate."
The prescribing pyramid

Reflect

Record Keeping

Review

Negotiate a contract

Choice of product

Which strategy?

Consider the patient

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!