The community Macmillan pharmacist project

Katy Mellor  MPharm, DipClinPharm

Katy Mellor describes her role as a Macmillan clinical pharmacist within a community end-of-life team in Hull that provides palliative care to patients with complex needs.

Our two-year Macmillan-funded project started in April of 2012 with the aim to set up a clinical pharmacy service within the community end-of-life team in Hull.

Prior to my role as a community Macmillan pharmacist, I spent 12 years working as a hospital-based clinical pharmacist in Manchester (see Table 1). My colleague (the project funded two Macmillan pharmacists who would work as a team) had a very much more community pharmacy-based background, and the combination of our diverse backgrounds would prove invaluable.

Our main areas of work would be:
• within the multidisciplinary community palliative care clinics, which run twice a week and provide both clinic and domiciliary visits for complex palliative care patients
• within Dove House Hospice (our local hospice) providing clinical pharmacy services
• within the community healthcare teams themselves, supporting GPs, district nurses and the patients themselves.

How do we work within these areas?

Community palliative care clinics
These clinics were set up by City Health Care Partnership (CHCP) Community Interest Company (CIC) in 2010 and we currently run two per week in different localities of the city. This is set to rise to three per week due to increased demand. We visit patients at home where necessary and also provide appointments in a clinic setting within appointed health centres. We work within a team comprised of a speciality doctor and Macmillan nurses to provide palliative care to patients with complex needs.

As Macmillan palliative care pharmacists, Katy Mellor and Melinda Presland provide prescribing advice and medicines information to a multidisciplinary end-of-life team, conduct comprehensive drug histories and medication reviews, and provide bespoke information and support to patients.
The pharmacist’s role within this team involves the taking of a comprehensive drug history, in preparation for the clinic sessions, and conducting thorough medication reviews. We advise on drug interactions, pharmacokinetics, side-effects and the optimisation of a patient’s drug therapy. We also advise on the discontinuation of long-term drugs, which can be an emotive subject in an end-of-life patient.

The pharmacists provide bespoke medicines information to each patient based upon their needs and their choices regarding their medications. We provide reminder charts, pain diaries and patient information leaflets about off-license and rarely used drugs, which can help to alleviate concerns about the use of medications outside of their license, a common practice in palliative care. We also support the wider multidisciplinary team by providing prescribing advice and medicines information on complex medication issues that often arise.

A pharmacist’s broad knowledge on the use of drugs is an invaluable asset to a specialist team. Pharmacists are trained in the use of drugs in not just one specialist area, but all bodily systems and various medical conditions. This provides a broad range of specialist medication-related knowledge for the team, not just in their specific area of palliative care.

Another major role of the pharmacist within the clinic team is to ensure the effective communication of any medication-related changes that are made by the clinic team to the wider healthcare community (ie GPs, district nurses and community pharmacists).

During our two-year pilot period the other pharmacist has completed the independent prescribers qualification and is now a qualified nonmedical prescriber. This further enhances the role of the pharmacist within the team, allowing her to visit patients within their homes following the initial multidisciplinary team visit and make changes to any medications we may have started (eg titration of an analgesic dose). This further streamlines the service of the team and improves patient access to medication.

Dove House Hospice

We currently visit Dove House Hospice twice weekly and provide a clinical pharmacist service to the wards. This involves the clinical assessment of the patient’s drug charts, ensuring that the patients have accurate drug histories, and attending ward rounds with the medical team when required. We also attend the weekly multidisciplinary team meetings at Dove House, which allows us to have clinical pharmacy input at this stage and identify patients who may soon be discharged and may need our help on returning back to their home environment.

Community healthcare teams

Our role within the community healthcare team is to be available as a specialist pharmacist resource to all in the field of palliative care including GPs, district nurses, community pharmacists, patients and carers. We provide training to the district nurses as part of the End-of-Life Academy, which we run as part of the Macmillan team, providing training on various medication-related areas of palliative care, for example pain relief and nausea and vomiting. We have also provided similar training to the out-of-hours end-of-life team.

We are also currently producing a training package on the pharmacology of palliative care drugs, for the local GPs, and we are putting together a training evening for local community pharmacists to encourage their role within the wider palliative-care team.

Our aim is to ensure the effective communication of palliative medicines information and training across the wider community team (and patients and carers) to enhance the skills in order to provide excellent end-of-life care.
Another recent addition to our service is the provision of a discharge support service to palliative patients being discharged from hospital. After referral from our hospital colleagues, we can visit the patients in their homes after discharge to ensure that they are able to manage any changes that may have been made to their medications while in the hospital.

Why is it useful to have a pharmacist in the multidisciplinary team within the community setting? There are a number of ways in which we can improve the use of medicines within palliative care in the community, and there are many factors that affect the judicious use of medicines in this field (see Table 2).

For many years, palliative care specialists have been using medicines for off-license indications or via unlicensed routes of administration. Although a large body of anecdotal evidence may exist to support this, in some cases the lack of evidence has permitted some medicines use that would not have had consensus support. The pharmacists can support GPs and other healthcare professionals in making informed decisions about the use of medications in this way.

There is also a lack of formal data about the stability and compatibility of some drugs commonly mixed in syringe drivers for palliative care patients, and the pharmacists provide advice to GPs and other professionals on this topic.

Polypharmacy is a real risk for patients, which has a significant impact on their quality of life, whether via tablet burden, side-effects, drug interactions or reactions. The Macmillan pharmacists in the community provide a regular medication review service for palliative care patients. This can free up GP time, which may be spent on these lengthy reviews, and provides another specialist professional opinion.

There is a real lack of written information on the use of drugs in palliative care that are being used off-label or outside of license. We are currently putting together a collection of patient information leaflets to improve patient access to information.

**Conclusion**

There is an increased demand for palliative care patients to be cared for in the community and this places increased responsibility on general practice through the initiation/continuation of appropriate medicines and the ongoing management of these patients. This results in a greater need for the support of general practice from specialist services such as our Macmillan palliative care pharmacist team.

*Katy Mellor is a Macmillan palliative care pharmacist, City Health Care Partnership CIC, Hull*

**Table 2. Examples of factors that affect judicious use of medicines in palliative care**

- there is insufficient guidance for the use of medicines where the evidence is not clear or is still emerging and where information is not readily available, especially where medicines are being used off-label or outside of license
- our specialist knowledge can be used to influence prescribing within GP practices to improve the quality of palliative care in the community
- there are gaps in knowledge and fear around the use of opioids by patients and some healthcare professionals
- there is a lack of guidance for prescribers in withdrawing medications towards the end of a patient’s life (e.g., long-term medications such as statin therapy)
- there is a need to better engage GPs and other key healthcare professionals in providing care at the end of life