



An exploratory evaluation of the pharmacist prescriber service within a mental health trust.

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Abstract

Introduction

Pharmacist supplementary prescribing (SP) was first suggested in the Crown Report in 1999¹. SP authorised pharmacists who had undertaken appropriate training to manage patients under the direction of a clinical management plan (CMP) in partnership with their patient and independent prescriber. Since its introduction, a number of pharmacists have undertaken this extended role within the mental health secondary care setting. The aim of this study was to investigate a pharmacist SP service provided in a secondary care mental health setting from the perspective of the service user.

Method

Approval was granted from an NHS Research Ethics Committee and NHS Trust R&D Committee. A multi-staged methodology was utilised. Patients were recruited via their SP pharmacist and written consent obtained. The first stage explored the interaction between pharmacist and patient through non-participant observation and audio-recording of consultations. A semi-structured interview was conducted following the consultation and patients were provided with a diary to record their views of the service over the subsequent six week period. A final semi-structured interview was then held to discuss the service as a whole.

Results

Twelve patients were recruited, and eleven participated in data collection. For the majority of consultations a similar structure was identified, each lasted between 10 minutes and one hour. The purpose of the interaction was to discuss patient progress since the last meeting. The pharmacist gathered information from the patient regarding their experience of taking medication, identification of side effects and patients' general well-being such as diet, sleeping habits and family life. The focus of the interaction was not solely on medication and included discussions of other non-pharmacological interventions. Patients were involved in the interaction to a great extent and their views sought on any suggested changes to therapy. Patients were also encouraged to ask questions and both parties shared common interests or experiences. At the end of the consultation a supply of medication was provided, if appropriate, and a further appointment arranged. The interactions showed similar features to some consultation frameworks; however, it is clear that a framework appropriate to pharmacist prescribers within the mental health setting is not readily available.

Semi structured interviews revealed that patients were satisfied with the service and felt that they had a positive relationship with their pharmacist. They compared their current care to previous experiences and commented on the increased consistency and availability of care. The pharmacist was also felt to be more engaging with the patients and willing to take their views into consideration, leading patients to feel they were in a partnership. Both the personality and the knowledge of the pharmacist were deemed to be important in developing their relationship. Patients believed that a different approach to the consultation was required when caring for those with a mental rather than physical illness and that this was successfully achieved within the service. Patient views were unchanged throughout the multiple stages undertaken.

Conclusion

This study has highlighted that it is possible to carry out a multi method study over a period of several weeks to explore the views of patients with mental illness on a pharmacist prescribing service. It is encouraging that the predicted benefits of such a role have been fulfilled in practice, albeit in a small sample of patients.

1. Department of Health. (1999). *Review of Prescribing, Supply and Administration of Medicines. Final Report*. London: Department of Health.

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Chapter 1: Introduction

Traditionally, the role of doctors has been to diagnose illness, and prescribe treatment where appropriate, whilst the pharmacist dispenses and supplies the prescribed medication to the patient. However, more recently pharmacy as a profession has evolved and undertaken a more patient focussed role.

In 1999 the Crown Report (Department of Health (DoH), 1999a) was published and indicated that healthcare professionals (HCPs) other than doctors and dentists were suitable to assume prescriber status. Two types of prescriber were identified, namely an independent prescriber (IP) and a supplementary prescriber (SP). At the time of the report, an IP was defined as either a doctor or dentist, whilst pharmacists were deemed suitable to become SPs. Supplementary prescribing was defined as:

‘a voluntary partnership between the independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient’s agreement’ (Royal Pharmaceutical Society of Great Britain (RPSGB), 2003)

The IP retained responsibility for making the initial diagnosis and initiating treatment. However, the on-going care of the patient, including prescribing could be entrusted to the SP under the direction of a clinical management plan (CMP). The CMP requirements stated that it must be patient and condition specific and a shared agreement between the IP, SP and patient. The plan must clearly detail the responsibilities of the pharmacist such as the medication they prescribe, when patients are referred back to the IP and when a clinical review by the IP occurs (RPSGB, 2004). In order to fulfil this role, the SP is required to have access to the appropriate patient medical records (Mullan, 2003). Patients with chronic conditions, such as mental health patients were considered likely to benefit from such a development.

Management of chronic diseases has become an increasing challenge to the National Health Service (NHS) with approximately 17.5 million adults suffering from a chronic disease within Great Britain. Individuals with chronic diseases are reported to take up to 80% of general practitioner consultations and occupy 60% of hospital beds (DoH, 2004). The DoH (2004) recognised that use of multi-disciplinary teams is an effective way to manage these conditions and includes non-medical prescribing. Supplementary prescribing was one approach adopted by the devolved Governments to modernise health care in the United Kingdom and was recognised in documents such as ‘The NHS Plan’ (DoH, 2000) in England and ‘Improving health in Wales’ (Welsh Assembly Government, 2001). Predicted benefits to patients included more effective use of HCPs’ skills and knowledge, enhanced access to healthcare, greater treatment choice and health care advice, improved management of medication, and an improved working relationship between HCPs (DoH, 1999a; MCA and DoH 2002).

In order to become a SP pharmacists are required to complete additional training. This includes approximately 26 days learning at a higher education institution and 12 days in practice with the designated medical supervisor (Wilson, 2003). After qualifying, pharmacists register as a SP with the RPSGB (now General Pharmaceutical Council) and their entry on the register is annotated to include ‘SP’. The concept of supplementary prescribing for both pharmacists and nurses became a reality at the same time (DoH, 2002), the first pharmacists to register as SPs did so in 2004 (Anon, 2004). However, since then other appropriately

qualified healthcare professionals, such as podiatrists, can carry out this role (MHRA and DoH, 2004).

In 2005 the DoH (2005a) published 'New ways of working for psychiatrists'. This initiative supported the use of multidisciplinary teams in order to promote patient-centred care. This included delegation of certain tasks within the team, raising the profile of mental health pharmacists and promoting supplementary and independent prescribing. In addition, the Healthcare Commission supported non-medical prescribing and HCPs, patients and carers working together to ensure the most positive outcome of care within mental health (Healthcare Commission, 2007).

Following the introduction of supplementary prescribing, the role has been extended with the establishment of independent prescribing. An independent prescriber is defined as 'a practitioner (e.g. doctor, nurse, pharmacist) responsible for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing' (MHRA and DoH, 2005 p6). In contrast to an SP, an IP does not prescribe within the confines of a CMP. The prescriber therefore practices with greater autonomy, although there are some legal restrictions on what can be prescribed, most notably controlled drugs.

In order to improve patient care it is imperative that service user views are sought. Indeed, in the document "Creating a patient-led NHS. Delivering the NHS improvement plan", the DoH supported a 'patient-led NHS' where patients should be given more information and greater choice of care. The NHS should also be 'better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction' (DoH, 2005b, p5). In 2001, the DoH stated that patient views should be heard in order to facilitate improvements to services (DoH, 2001a). In addition, the Government's vision for mental healthcare summarised recent policies and stated that the needs of carers of mental health patients should be addressed and that the care received should be 'effective and acceptable' (DoH, 2001b).

Importantly, pharmacist prescribing has been incorporated into practice in both primary and secondary care to treat cardiovascular, oncology, respiratory (Stewart *et al.*, 2009a) and mental health (NPC, 2010) conditions. There are currently over 2500 qualified pharmacist prescribers in the UK (CPPE, 2010). However, the implementation of these roles into practice has not been without problems, which have included developing the necessary CMPs, and obtaining access to medical records, prescription pads, and funding (Cooper *et al.*, 2008a)

In light of these Government policies and practice developments this study aimed to investigate a pharmacist SP service provided in a secondary care mental health setting from the perspective of the service user. It concentrated on pharmacists who were regularly consulting with, and managing patients with long term mental illnesses including schizophrenia, depression and bipolar disorder.

The study objectives were:

- 1) To describe the service provided to mental health patients in the study setting.
- 2) To describe what is involved in a pharmacist SP-patient consultation.

- 3) To investigate the views of service users within this service on being managed by a pharmacist SP.

The next chapter, Chapter two, will place this study within the wider context of the research literature. Chapter three will then describe the research questions and the methodology employed to answer the questions at each stage of the study. Chapter four will present the results obtained and finally, Chapter five will discuss the findings in relation to previous studies and highlight further work.

Chapter 2: Literature review

This chapter aims to discuss the research already conducted on different aspects of non-medical prescribing and its relevance to this project. This includes studies exploring the views of patients and HCPs on the extended role, those related to mental health nurse prescribing and studies which support the need for additional research to explore patient views.

Search strategy

The databases used to access the literature included Embase, Ovid, Medline and Web of Knowledge. In addition, Zetoc Alerts were utilised incorporating a number of pharmacy and health journals in order to access up-to-date articles. Keywords used were 'mental health', 'pharmacist prescribe*', 'supplementary', 'supplementary prescrib*' 'patient satisfaction' and 'consultation'. The search was carried out between January 2009 and October 2010 and focussed on research papers and appropriate policy documents.

A number of studies have been conducted since the implementation of non-medical prescribing. Due to the topical nature of the role and the opportunities it allowed for increased autonomy this was a pertinent time to conduct exploratory research. The literature review concentrated on those studies focusing on supplementary prescribing due to the nature of the prescribing role undertaken by the study pharmacists.

Child and colleagues (1998), Child and Cantrill (1999) and Child (2001) explored the views of HCPs on the concept of pharmacist prescribing. These were small scale studies conducted in Birmingham hospitals. Those HCPs who had some experience of pharmacist 'prescribing' were positive of such a role, although they believed that it should only be implemented with additional postgraduate training (Child *et al.*, 1998). Barriers to pharmacist prescribing identified included the lack of 'familiarity' the pharmacist had with their patient, including details of their condition (Child *et al.*, 1998; Child and Cantrill, 1999) and the pharmacist's ability to review the patient's drug therapy and appropriately act upon it. These views were expressed before supplementary prescribing became a reality and were conducted within acute NHS Trust hospitals. Mental health patients are often seen on a regular basis by a HCP for a prolonged period of time. The observations regarding the prescriber's relationship with the patient and the ability to review therapy may not be such a concern within this context due to the extended duration of treatment.

A number of research projects have been conducted investigating different aspects of supplementary prescribing and its implementation within the United Kingdom. HCPs' views on pharmacist prescribing have been explored by a number of researchers including doctors and nurses (Buckley *et al.*, 2005; Buckley *et al.*, 2006), chief pharmacists and primary care pharmacists (Hobson and Sewell, 2006a), general practitioners (Blenkinsopp *et al.*, 2008), hospital nurses (Lloyd *et al.*, 2005a), junior house officers (Lloyd *et al.*, 2005b) and community pharmacists (While *et al.*, 2004). In general, these small scale studies have illustrated acceptance of the concept of pharmacist prescribing. However, suitable training was believed to be necessary with some participants also concerned about pharmacists taking on a role traditionally carried out by doctors (Buckley *et al.*, 2006; Lloyd *et al.*, 2007a). Indeed, some GPs selectively referred patients to their SPs in order to maintain some control over the pharmacist's role (Blenkinsopp *et al.*, 2008). These studies have given an insight into the

views of HCPs on this development but have not provided a voice for the patient experiencing the new role.

SP pharmacists' views with regards to the training programme have been investigated (Dawoud *et al.*, 2004; Cooper *et al.*, 2008b). In addition, the responsibility and implementation (including the barriers to supplementary prescribing) of such an extended role (Latif *et al.*, 2005; Hobson and Sewell, 2006b; Tully *et al.*, 2007), their communication skills (Cleland *et al.*, 2007) and early experiences of supplementary prescribing (George *et al.*, 2006) have been explored. Weiss and colleagues (2009) investigated a concern raised at the onset of non-medical prescribing, that of pharmacists and other HCPs encroaching on the role of the independent prescriber (medical practitioner). They conducted interviews with a small sample of pharmacist SPs and concluded that non-medical prescribing has not compromised the dominance of the medical profession so far. Weiss and colleagues (2006) also conducted a multi-staged project to evaluate pharmacist supplementary prescribing. This involved a case study approach including views of SPs, patients and other HCPs. They highlighted that there should be an increased awareness of supplementary prescribing by patients and professionals alike as many of the patients were not fully aware of the SP's role.

Supplementary prescribing is essentially a three-way partnership between the IP, SP and patient. However, little research has been conducted on the views of the service user or outcomes of treatment (George *et al.*, 2006; Tonna *et al.*, 2007; Cooper *et al.*, 2008a; Stewart *et al.*, 2009a). Instead, as described above, research has focussed on the views of pharmacists, other HCPs and descriptions of supplementary prescribing in practice. Hobson and Sewell (2006a) stated that there is a need to 'support research into the role in order to provide an evidence-base that supplementary prescribing is providing patients with at least an equivalent service to doctors, and is also increasing access to healthcare for patients, without compromising safety' (p89). Hodgetts and Wright (2007) investigated the views of patients within the field of psychotherapy. They recognised that the views of the service user in general mental health services needed to be explored to ensure that treatment is appropriate for the individual.

Positive views have been reported by pharmacist SPs in terms of potential patient benefits. This has resulted from improved management of their condition and increased satisfaction with the service (George *et al.*, 2006). These, however, were perceived by those implementing the service, not the patients themselves. Other stakeholders such as doctors, policy leads and patient groups (Cooper *et al.*, 2008c) have also expressed mainly positive views on the role, albeit with some reservations.

A number of small scale studies have explored the views of patients on the pharmacist supplementary prescribing service. Smalley (2006) surveyed patients in a pharmacist SP hypertension clinic. This was held in primary care and reported that patients were satisfied with the service, believing that they understood their condition to a greater degree. However, a limitation of this study was that 91% of responses were received from patients continuing to attend the clinic which may have been biased towards a positive attitude. Interestingly, Smalley (2006) allowed for appointment times which were double those normally used (20 instead of 10 minutes) which may have impacted positively on patient satisfaction.

Shulman and Yani (2005) compared the prescribing practices of doctors and pharmacist SPs with reference to haemofiltration anti-infective prescribing guidelines. This small scale study demonstrated that the pharmacists prescribed in accordance with appropriate guidelines to a greater degree than doctors (100% compared to 55%). However, no such comparison in pharmacist mental health supplementary prescribing has been completed to illustrate the effectiveness of care management.

Lloyd and colleagues (2007b), Stewart and colleagues (2007a; 2008; 2009a; 2010) and Hobson and colleagues (2010) have investigated the views of a small number of patients on pharmacist prescribing. A positive response was received where patients reported satisfaction with their consultation. In addition, patients believed that pharmacists told them everything about their treatment and they had a high degree of trust in the ability of the pharmacist to prescribe before their first consultation. However, 65% of patients preferred to see their doctor if they were given the choice. In some studies (Stewart *et al.*, 2008; 2009a; Hobson *et al.* 2010) a purposive sample was utilised and the prescribing pharmacists were used to identify potential patients which may have introduced some selection bias.

In contrast to exploring patients as participants, Stewart *et al.* (2007b; 2009b) asked the general public about their views on non-medical prescribing via a survey. Issues raised (Stewart *et al.*, 2007b) included confidence in the ability of pharmacists to prescribe, the range of medicines they are able to prescribe and privacy. Even though more than half of these participants were aware that non-medical professionals could prescribe it is unclear whether they had any direct experience of their role and therefore how informed their views were. Over half of the participants in 2009 (Stewart *et al.*, 2009b) were in support of pharmacist prescribing, however, fewer patients supported pharmacist diagnosing or that they should be able to prescribe the same medicines as a physician.

Happell and colleagues (2004) recognised that little research has been conducted on the views of mental health service users. However, previous research has shown patients with a mental illness to be dissatisfied with the information provided about their medication and their ability to participate in the decisions regarding their care (Happell *et al.*, 2004, Gray *et al.*, 2005; Paton and Esop, 2005). The use of SPs to manage patients with mental health conditions, may improve service satisfaction. Indeed, pharmacist prescribing has been introduced into the mental health setting both in England and Wales and is supported by the UK Psychiatric Pharmacy Group (UKPPG) (UKPPG, 2003). The UKPPG stated that patients and NHS Trusts would benefit from the role of a pharmacist SP. There is a lack of literature exploring the views of mental health patients on pharmacist supplementary prescribing, in contrast to mental health nurse prescribing, where a number of studies have been conducted (Jones *et al.*, 2007; McCann and Clark, 2008). For example, Jones and colleagues (2007) carried out semi-structured interviews with mental health patients to explore their views on a nurse supplementary prescribing service, whilst Page and colleagues (2008) investigated the views of both patients with dementia and their carers on a nurse prescribing service. Small scale studies have also been conducted exploring the views of psychiatrists and nurses on nurse supplementary prescribing within mental health (Tomar *et al.*, 2008; Rana *et al.*, 2009).

George and colleagues' (2006) baseline survey included all pharmacist SPs. All other studies, including views of healthcare professionals, implementation and outcomes of supplementary prescribing and patient views found in the literature often used a purposive or convenience, small sample. As a result, the findings from these studies cannot be generalised to other

situations. Importantly, as the concept of supplementary prescribing is inclusive of a prescriber and patient partnership it is important that the views of the service user are explored.

Chapter 3: Methods

This was a multi-method project which aimed to investigate the pharmacist SP service from the perspective of the service user. The study was conducted within a mental health secondary care out-patient setting in South Wales. A multi-staged, longitudinal methodology allowed the views of each participant to be gathered over a longer period of time. This gave the opportunity for patients to reflect on the service and express their thoughts beyond the immediate 'snap shot' approach.

Qualitative methodology was deemed most appropriate to explore the views and perceptions of the participants on the service (Smith, 2002). A number of research methods were employed, namely non-participant observation, interviews and diaries. The study protocol is summarised in Figure 3.1.

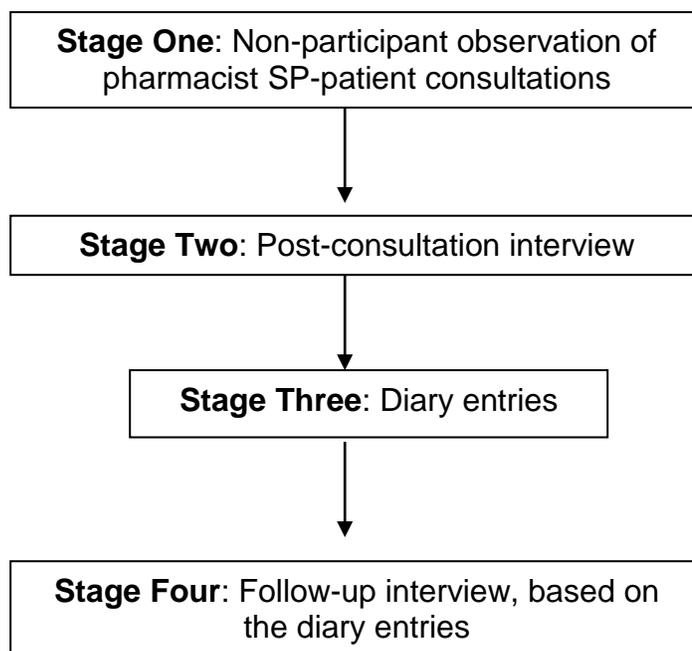


Figure 3.1: Summary of the study design.

3.1 Research questions

The research questions addressed at each stage of the study were as follows:

Stage One: Non-participant observation of pharmacist- patient consultation

- 1) What was involved in a pharmacist SP-patient consultation?
- 2) How did the pharmacists and patients interact during their consultation?

Stage Two: Patient interviews post-consultation

- 1) What were the views of the patient regarding the most recent consultation with their pharmacist SP?
- 2) How should the pharmacist-patient consultation be best conducted in order to address patient needs?

Stages Three and Four: Diary completion and diary follow-up interview

- 1) What were the views of the patients on being managed by a pharmacist SP?

- 2) What advantages and disadvantages did the patients see in pharmacist SPs managing their care?
- 3) How should the pharmacist SP service have been conducted in order to ensure that patient needs were addressed?

This next section describes each stage of the project in detail, including the rationale for choosing the method to address the research questions, recruitment and operationalisation.

3.2 Recruitment procedure

The inclusion criteria for all participants were as follows:

- Adult (18 years old or over).
- Patients must have had their treatment managed by the pharmacist SP.
- The pharmacist must have seen the patient for a minimum of two consultations in order to ascertain their appropriateness for inclusion.
- The patient must have been capable of providing consent.
- If the patient was being looked after by a carer, this must have been a consistent person, such as a family member and both carer and patient consent obtained.

The exclusion criteria were as follows:

- Patients deemed inappropriate either by the pharmacist or IP; there had to be agreement from both.
- Patients or carers who were unable to provide consent.
- Patients who were looked after by carers who may not have been consistently present at the consultations.

Before patient consent was obtained, both the pharmacist SP and their respective IP(s) were required to provide their consent as follows:

Pharmacist SPs and IPs

Purposive sampling was utilised to identify practicing pharmacist SPs within the study setting via known contacts of the researcher. The SPs were then invited to meet with the researcher to explain the study and were provided with an information pack (information sheet, a letter inviting participation and consent form) explaining what would be expected of them. The pharmacists were given the opportunity to consider the information and were asked to consent to being observed in consultation with their patients and to act as a gatekeeper to their patients and their respective IPs.

Once the pharmacist had provided written consent they were asked to forward an information pack onto their respective IPs. Once the IP had provided written consent the appropriate patients of both the SP and IP were approached for recruitment into the study. If a consent form had not been received from the IP after fourteen days the pharmacist was asked to forward another information pack as a reminder.

Patients

The consenting SP and IP worked in partnership to identify individual patients who met the inclusion criteria. An ideal target recruitment of 15 patients was deemed to be reasonable. The protocol required an agreement between the prescribers in order to minimise any

potential selection bias that may have resulted from the pharmacist identifying patients alone. Potential participants suffered from schizophrenia, depression, bipolar disorder or dementia.

The pharmacists were provided with a number of patient information packs which they distributed to potential participants during a routine consultation. The patient was given the opportunity to take the information away to consider and return a signed copy of the consent form to the researcher if they wished to participate. If consent was not received after fourteen days the pharmacist contacted the patients and supplied another copy of the pack, if necessary. Guidance was given to the pharmacists in terms of their role in recruitment and to ensure patients were not being coerced in any way.

Patients were asked to consent to all four stages. However, the consent form allowed flexibility in terms of which stages patients consented to. Patients were able to withdraw from the study at anytime without giving a reason. Once consent was received observation of the next pharmacist SP-patient consultation took place.

Patients with carers

A small number of patients with dementia were being cared for by a regular carer. The Mental Health National Service Framework (DoH, 1999b) has clearly recognised the importance of the carer's role and therefore their views on the service were sought. It was deemed suitable to only recruit patients who were cared for by a regular carer, such as a family member. If a different carer attended each consultation they may not have had sufficient knowledge of the care provided by the pharmacist to give an informed opinion. Patients with carers were approached in the manner described above. The information pack provided was tailored to the patient and carer and both parties were required to provide written consent.

3.3 Participant demographics

Once each patient (and carer, if appropriate) had provided written consent to participate the appropriate SP noted patient demographic information (age, gender, ethnicity, language, condition being treated, co-morbidities and duration of treatment by pharmacist) on a brief questionnaire (Appendix One). The information was recorded anonymously with only the designated participant number noted.

3.4 Stage One: Non-participant observation of SP-patient consultation

Non-participant observation was utilised in order to investigate the interaction between the pharmacist and participants. This method has been recognised as providing an insight into health care settings (Mays and Pope, 1995) and has been used in combination with other methods such as interviews within pharmacy practice research (Smith, 2002) in both primary (Savage, 1996) and secondary care (Cooper *et al.*, 2004; Jones *et al.*, 2006).

This method allowed the researcher to be present within the field of study and to observe what was happening, they did not take part in the activity being observed; instead they watched and recorded data in the form of field notes and audio recordings. Adler and Adler (1998 p81) define non-participant observation as 'simple observers follow the flow of events. Behaviour and interaction continue as they would without the presence of a researcher, uninterrupted by intrusion'. It was imperative that the researcher kept their distance from the interaction to allow the pharmacist and patient to interact as if they were not there. The researcher therefore positioned herself to the side of the participants to minimise inclusion.

The consultations were audio recorded, with consent and field notes taken by the researcher. The notes detailed the non-verbal aspects of the interaction which would not have been captured otherwise. All of the information recorded and noted during the interaction was kept confidentially and anonymised. Video recording was considered, however, the research team believed that this may have affected participant recruitment to a greater extent than audio recording due to the sensitive nature of the interaction.

3.5 Stage Two: Patient interviews post-consultation

The second stage of the study was conducted immediately after the SP-patient consultation. Participants were given the opportunity to discuss and reflect on their consultation while it was fresh in their minds. It was also possible for the researcher to draw on the consultation field notes to explore participant views on the interaction.

Semi-structured interviews, which are widely used within social science research (Stroh, 2000; Flick, 2002) were used to allow an open discussion of the consultation. An interview schedule (Appendix Two) was used which detailed a small number of key open questions and topics (Kvale, 1996). The schedule was piloted with the first recruited patient and minor amendments made, where necessary. Open questions were utilised in order to encourage the interviewee to express their views and opinions freely, This was in contrast to closed questions, that may have influenced responses (Foddy, 1993). The freedom to answer the questions in this way allowed the interviewee to discuss and raise issues that were important to them (Bryman, 2001). The interview was therefore 'respondent-led' (Smith, 2002). The interview was to be held jointly with both the patient and their carer where both parties had consented.

3.6 Stages Three and Four: Diary completion and diary follow-up interview

In order to address the participant's general views on the SP service two additional stages were undertaken. The details of these stages are described below.

Diary completion

At the end of the post-consultation interview the participants were provided with a research diary (Appendix Three) to be maintained over a period of six weeks. Participants were requested to record events or incidents related to the care received from their SP, the medication they were prescribed and their interactions with the pharmacist. The participants were provided with the researcher's contact details and guidance on how to complete the diary. To encourage patients to complete their diary entries and to answer any questions the researcher telephoned or emailed (whichever was most convenient) the participant mid-way through the diary period. This strategy has proved successful in previous studies (Frankland, 2002) Contact was also made at the end of the diary period to remind participants to return the diary. This contact was believed to increase participant motivation and the quality of the entries (Verbrugge, 1980; Frankland, 2002).

Diaries have previously been used successfully in health services research (Richardson, 1994), for example, exploring the nature of communication between community pharmacists and general practitioners (Kennedy *et al.*, 1997) and recording illness episodes (Frankland, 2002). An advantage of this 'researcher-driven' (Jones, 2000) diary was their 'closeness' to the event recorded (Elliott, 1997). A prospective use of diaries ensured that thoughts or ideas were recorded at the time of occurrence (Verbrugge, 1980) and therefore the diarists did not

have to rely on their memories to such a great extent (Richardson, 1994) when they were later discussed. The diary entries were discussed in a follow-up semi-structured interview. This is known as the diary: diary-interview method and had the advantage that it enabled the researcher to explore the meaning participants had given to certain occurrences (Zimmerman and Wieder, 1977).

This stage of the study allowed participants to reflect on the care provided by the pharmacist over time and to note any issues that occurred. Participants were not required to make a record on a daily basis. Both patient and carer, if appropriate were requested to share the same diary (Appendix Four). The participants were asked to keep the diary in a convenient place, in order to record thoughts or events as they arose and to anonymise any entries. After a period of six weeks the diaries were returned to the researcher. The contents of the diaries were analysed through content analysis and utilised as prompts within the final follow-up interview.

Follow-up interview and SIMS questionnaire

The final stage of the study consisted of a further semi-structured interview. The interview schedule used is presented in Appendix Five. Where possible, the interview was held after an appointment with the pharmacist to minimise inconvenience to the patient. Alternatively, a mutually agreed time and place was arranged. If a carer was participating, the interview was to be held jointly with the patient. In this final interview participants' opinions and 'satisfaction' of the service as a whole were investigated. The interviews took place as soon as possible after completion of the diaries so that participants would have to rely on their memories as little as possible (Frankland, 2002).

At this time participants were asked to complete a brief questionnaire to determine their satisfaction with information provided to them regarding medication prescribed by the SP (Satisfaction with Information about Medicines Scale (SIMS)) (Horne, 2001). The SIMS questionnaire has previously been validated in bipolar disorder (Bowskill *et al.*, 2007). If both patient and carer were present then both parties were to complete a SIMS questionnaire to gather individual responses. The answers provided were also used as a means of facilitating discussion.

3.7 Confidentiality – data collection

All of the data collected from the non-participant observation, interview and diaries were anonymised before analysis. All information was kept confidential and only viewed by members of the research team. Participants were reassured of the confidentiality of their views and that their treatment would not be affected in any way by their participation.

3.8 Data analysis procedure

The data gathered in each stage were analysed in the following manner:

Stage One: Non-participant observation of SP-patient consultation

The information obtained from the consultations (audio recordings and field notes) were transcribed and used to describe the interactions. This included details such as the information provided by the pharmacist, the questions asked of both parties and the non-verbal aspects of the interaction.

Stage Two: Interviews post-consultation

The transcribed interviews were analysed by identifying themes via the code and retrieve method of analysis, the main form of qualitative data analysis (Babbie, 2001). Code and retrieve is a form of data reduction. In order to assist with data management and storage the Computer Assisted Qualitative Data Analysis Software N6 was used which allowed sections of the interviews to be labelled with and hierarchies of codes to be saved electronically. The study was based on a grounded theory approach (Babbie, 2001) which is the most commonly used approach to qualitative data analysis (Bryman, 2001).

Stage Three and Four: Diary completion and diary follow-up interview

The diary entries were analysed by content analysis (Neuendorf, 2002). The follow-up interviews were analysed in the same manner as the post-consultation interviews. For the SIMS questionnaire a score of 1 was given to an answer of 'about right' and 'none needed' and a score of 0 to an answer of 'too little', 'too much' and 'none received' for each of the 17 categories. The greater the score, the more satisfied the patient was.

3.9 Participant incentives

In order to thank the participants a small monetary payment was made, £10 for each of the interviews in stages two and four and £5 for diary completion. No payment was made for stage one (observation) as the patient was present at the appointment regardless of the research. If a patient's carer also participated they received the same payment as the patient.

3.10 Ethics approval process

As the study involved the participation of patients and NHS staff, approval was requested and granted from a research ethics committee (National Research Ethics Service, 2009) and the Research and Development Office of the relevant NHS trust.

Chapter 4: Results

This chapter will present the results of the study. All of the data have been anonymised and participants allocated a code to maintain confidentiality. Both of the pharmacist SPs (SP1 and SP2) working in the department were approached and agreed to take part in the study. Six IPs who worked in partnership with SP1 consented, as did two IPs for SP2.

4.1 Participant recruitment

In total, 13 information packs were provided to suitable patients by the SPs. Of these, 12 were recruited out of the target 15; none were in partnership with a carer. All of the patients were being cared for by SP1 and consented to take part in every stage. The stages that each participant completed and the total participating per stage is presented in Table 4.1. Due to unforeseen circumstances PT3 was not able to participate in the data collection. For the remainder of the report participant one will be referred to as PT1, participant two as PT2 and so forth.

Table 4.1: The stages each patient completed.

Participant no.	Stage one	Stage two	Stage three	Stage four
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	-	-	-	-
4	✓	✓	-	✓
5	✓	✓	✓	✓
6	✓	✓	✓	✓
7	✓	✓	-	-
8	✓	✓	✓	✓
9	✓	✓	✓	✓
10	✓	✓	✓	✓
11	✓	✓	-	-
12	✓	✓	-	-
Total	11	11	7	8

4.2 Patient demographics

Patient demographics are summarised in Table 4.2.

Table 4.2: Patient demographics

	Number
Age range (yrs)	
18-29	3
30-39	3
40-49	3
50-59	0
60-69	2
Gender	
Male	3
Female	8
Diagnosis	
Bipolar disorder	8
Psychosis and depression	1
Depression	2

All of the patients were Caucasian and spoke English as their first language. Only one patient could speak an additional language to English. Some patients suffered with co-morbidities which included psoriasis, hypertension, poly-cystic ovary syndrome, menopause and an eating disorder. The average amount of time the SP had known the patient was 2.5 years and had treated the patient as a SP for 1 year, 1 month.

The results from each of the stages completed during the study are presented below:

4.3 Stage One: Non-participant observation of SP-patient consultation

Before each of the consultations began the researcher was welcomed by the pharmacist and introduced to the patient. At this time it was confirmed that the patient would still allow the researcher to be present and for the consultation to be audio-recorded.

4.3.1 Setting the scene

All of the patients had previously had consultations with the pharmacist in accordance with the inclusion criteria. The appointments were regular meetings between patient and pharmacist which took place every 2 to 8 weeks. The pharmacist greeted the patient outside the consultation room, in the waiting area. Thirty minutes was allocated per appointment, however, if a patient had greater needs more time was provided in order to cover any issues that arose. Therefore the duration of the appointments ranged from 10 minutes (PT2) to 1 hour (PT1). Consultations took place either in a consultation room within a community mental health team (CMHT) centre or in a meeting room in the hospital pharmacy department. The location and duration of each observation is given in Table 4.3.

Table 4.3. Location and duration of consultations.

Participant no.	Location	Duration (mins)
1	Hospital pharmacy dept	60
2	Hospital pharmacy dept	15
4	CMHT	31
5	CMHT	32
6	CMHT	25
7	CMHT	35
8	CMHT	30
9	Hospital pharmacy dept	47
10	CMHT	16
11	Hospital pharmacy dept	25
12	CMHT	16

4.3.2 Room layout

The manner in which the interaction was organised was consistent on each occasion. Typically, the pharmacist and patient sat facing each other at a slight angle. Even though there may have been a table in the room, it was not positioned between the parties, creating an open environment. A typical arrangement can be seen in Figure 4.1.

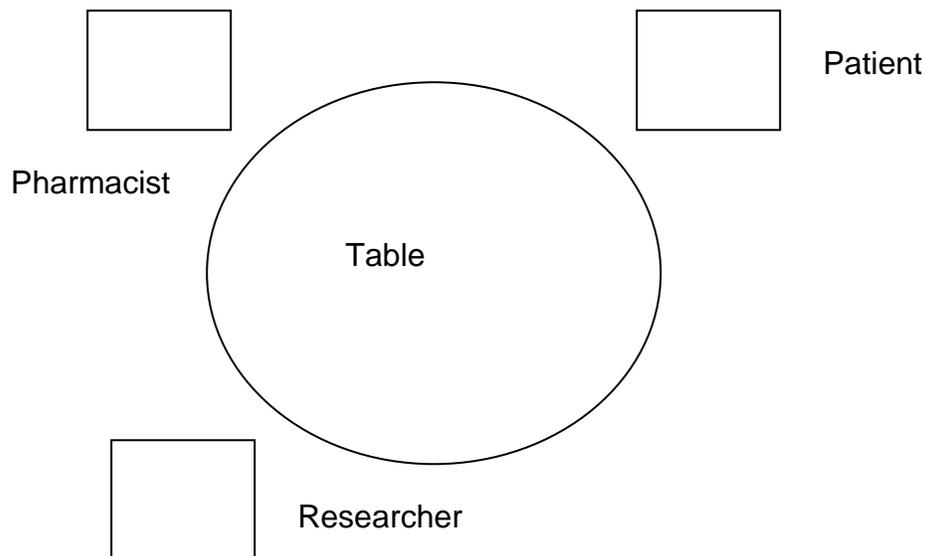


Figure 4.1. Consultation layout

4.3.3 Purpose and structure of the consultation

The purpose of the consultations was to discuss patient progress since the previous meeting. Each of the consultations followed a similar structure regardless of the patient's condition, with the exception of PT2. At the beginning of the consultation the pharmacist enquired about the time since they had previously met, usually with an open question:

PHARM (PT4) Give me an update, how are things since?

PHARM (PT6) So, how have you been?

This allowed the patient to elaborate on issues important to them which did not always involve their therapy (medicinal or otherwise). At this time the patients engaged in narrative, free from interruption, with the pharmacist listening. If the patient disclosed information relevant to their care the pharmacist would either probe further at that time or, as was evident in a number of consultations, would refer back to the issue raised later in the consultation. For example, if a patient had identified a side effect.

4.3.4 Information gathering

Throughout the interaction the pharmacist made written notes on the information provided by the patient, the consultation was used as a means of gathering information. Once the patient had elaborated on the time between meetings the pharmacist then asked a number of questions. The questions consistently covered the same issues related to the patients' well-being. These included:

- Mood levels

PHARM(PT6) What would you say your mood is at the moment?

PHARM(PT11)ok, so how's your mood been? Now we usually have a look at your mood diary don't we?

Patients were often asked to rate their mood with a numerical value from a pre-defined scale

PHARM What score do we give it [mood] out of 20, 10 being middle?

PT5 10 being middling, it'd be 13

- Sleeping habits

PHARM That's good, what about your sleep?

PT12 Um, I'm sleeping more than I have been

- Eating habits
- Work life
- Daily or weekly activities
- The patient's motivation and level of engagement in activities

PHARM Yeah, So how's your kind of motivation levels?

PT4 Haven't got any, not fair, that's what I miss

- (At times, issues related to alcohol and drug use were also asked)

These questions were mainly open in nature in order to allow the patient to expand and discuss their mood in relation to real life experiences. The questions then became more exploratory, seeking more detailed information. For example, the pharmacist would ask in detail what time the patient got to sleep at night or woke up. These questions were used in each meeting as a means of tracking the patient's progress. In addition, the patients appeared to be 'used' to answering these types of questions, on occasions volunteering

information themselves, illustrating their familiarity with the structure and types of questions covered:

PHARM *ok so what's your mood like at the moment?*
PT9 *um quite good I think*
PHARM *ok*
PT9 *um say about 7 out of 10*

4.3.5 The involvement of medication – dose and tailoring

In all consultations the pharmacological treatment of the patient's condition was discussed. None of the patients were initiated on new therapy during the interactions. Instead the pharmacist focused on establishing how the patient was tolerating their current therapy. This included questions around any identified side effects:

PHARM *What about side effects since we increased?*
PT8 *um I haven't seen any side effects um*
PHARM *rashes?*
PT8 *no I keep a close eye on it*
PHARM *ok, hallucinations?*
PT8 *no*
PHARM *good, any balance problems?*
PT8 *no*

If a side effect had been identified then the pharmacist questioned further to explore details. In PT2's interaction a potentially significant side effect had been identified. This meant that the focus of the interaction was on gathering in depth information including its timing relative to the patient taking their medication. This consultation was different to the other patients' due to the focus on this identified side effect.

Many of the patients had previously been initiated on medication that required a slow titration of the dose in order to achieve maximal affect (e.g. lamotrigine to treat bipolar disorder). As a result, the pharmacist would establish how the current dose was being tolerated and, if necessary the dose would be modified. In some cases, as the dose of one medication was being established the dose of another would be reduced.

Each time a change was suggested, the pharmacist, explained in detail why it might be appropriate and the patient was consulted on their views.

PHARM *so what do you think of this lamotrigine stuff then?*
PT5 *um*
PHARM *what's your thoughts on it?*
PT5 *I think I should stay on it. I don't think we should stop*
PHARM *But do you think*
PT5 *It's always hard to tell isn't it coz there's so many other factors*
 going on
PHARM *do you think it's made any difference, has it made you worse?*
PT5 *I don't think it's made me worse*

Patients were asked if they think a change in medication is required:

PHARM (PT1) *Ok, so, do we need to change anything or are you happy with the current?*

PHARM *excellent ok so what shall we do with your medication today then?*
PT12 *um yes I feel like I'm ready to go down again*

If a patient did not wish for their medication to be changed their views were adhered to and supported:

PT9 *and 20mg, no 10mg of escitalopram*
PHARM *now in the past you were on 20 weren't you?*
PT9 *yes*
PHARM *and I know that we've kind of had discussions around um whether we should increase it*
PT9 *right*
PHARM *or whether we shouldn't um so maybe that's something we need to have a think about today*
PT9 *I think I would rather leave it as it is*
PHARM *yeh you would ok*

In PT11's case they requested the dose change themselves:

PHARM *now then um so you want your olanzapine dropped again*
PT11 *yes please*
PHARM *so why do you want it dropped again?*

4.3.6 Non-pharmacological interventions

In addition to the pharmacological interventions discussed, a number of consultations involved the pharmacist suggesting other means to aid wellbeing. These included volunteering and attending support groups. These suggestions were made in order to assist the patient in avoiding a relapse in their condition.

PT9 *I feels like, I was saying to her it feels like I've been unwell for such a long time and I've been going through the system and I'm kind of like bored with it all*
PHARM *I mean why don't you, have you ever thought about looking at voluntary work?*
PT9 *yes, well they, when I went to (place) the last time, like on the Tuesday evening they were all like giving me suggestions about it*
PHARM *I mean work doesn't have to be anything to do with mental health*

PHARM (PT1) *What about something like voluntary work?*

In all consultations except PT2 (due to the focus on the side effects) and PT10 issues related to family life were touched upon. It was clear, due to the previous involvement of the pharmacist that they had prior knowledge of aspects of the patient's family history and routine, such as their work life and hobbies. The pharmacist was therefore able to refer to the individual patient's situation. Patients frequently discussed the involvement or affect of their family and friends in their illness and treatment, whether it be a negative or positive contribution.

Due to the nature of the conditions treated, many of the patients had contact with other HCPs. These included community psychiatric nurses, doctors, social workers and psychotherapists.

While discussing treatment with the pharmacist the involvement of these HCPs were touched upon illustrating how mental health is a multi-disciplinary area.

4.3.7 Interaction outside of the consultation

In some consultations reference was made to the pharmacist having contact with the patient and other HCPs beyond these face-to-face discussions. This included:

- The pharmacist answering queries related to medication (not only those used to treat the condition the pharmacist was managing) (PT5)
- Contacting other HCPs on the patient's behalf related to a medication query (PT7 and PT8)
- The pharmacist at times provided further written information in the post to patients who requested it (PT4)
- Where the pharmacist did not know the exact answer to a query they, in both instances (PT2 and PT7) informed the patient that they would contact the independent prescriber and discuss it with them. They would then inform the patient on the outcome of the discussion. This illustrates an example of the SP working within their competencies.

The pharmacist also offered the opportunity for patients to contact them between meetings should they have any queries.

PHARM (PT8) ok so we need to keep an eye on the tiredness then and switch to night. You've got my email address haven't you? So you can either, you know if you want to discuss it before you do it or you're not sure just drop me an e-mail asking me to ring you or, just let me know where you are, chat it over the phone. If I get an email I'll try and get hold of you.

PHARM (PT11) you've got my telephone numbers in case you need to contact me while you're away

4.3.8 Patient involvement

As described above a great deal of information was exchanged between the pharmacist and patient related to their therapy, family and social history. Every patient was an active participator in the interaction. Patients were given the opportunity to speak at length on any issues raised and contributed to the discussion on their care.

Patients were involved in their treatment, for example, PT4 was aware of test results that had been carried out previously on their liver. The pharmacist was therefore sharing test result information with the patient to keep them informed:

PHARM And I've just had a thought, when did we last look at your liver?
PT4 I think my liver was ok and but it was my blood cells were indicating I was having too much alcohol
PHARM Yeah, that was in May wasn't it?
PT4 Yeah
PHARM I'm just thinking whether it's worth getting that checked again and whether that's why you're not able to tolerate the dose of valproate you used to be able to tolerate.

At the beginning of PT5's appointment both patient and pharmacist, in jest comment on how it is the patient that leads the interaction with the pharmacist commenting:

PHARM Don't you always?

PT6, after a longer than usual break between appointments, the pharmacist is able to comment on the availability of a prescriber to amend their dose during that time:

PT6 yeh the the only thing I would say you know like you and um [doctor] were allowed to like do my prescriptions it would have been nice if she like jumped in a bit or just done some prescriptions for me to keep raising them up cos its like been

Some patients (PT5 and PT7) had, in their own time conducted some research on their condition which was shared in the consultations:

PHARM [laughing] ok so what about the lamotrigine then?

PT7 um because at the moment there is another reason for the imbalance I haven't yet managed to find any interesting rashes stay as it is, the stiff neck is certainly still there and apparently that affects about 2% of people which consistently the same to me, tight there so I've just increased the number of neck and shoulder exercises I'm doing at the moment

PHARM well you're the first one to have a stiff neck on lamotrigine

PT7 you'd be surprised 2% of people get a stiff neck on lamotrigine

PHARM 2%?

PT7 yeh

PHARM so if I've got a 100 people on it, I'll see 2, so you're the first one

PT7 you may have but they haven't told you

PHARM mmmm maybe I should ask them all

4.3.9 Asking questions

Patients, in a number of consultations asked questions either related to their condition or therapy. For example, PT5 queried how their bipolar medication affected their contraceptive pill and PT8 required confirmation of their condition to know how it was 'labelled'.

4.3.10 Opportunity to ask questions

At the end of the consultation patients were given the opportunity to raise any issues or ask questions, for example:

PHARM (PT1) Anything else you want to ask?

PHARM (PT10) Anything else you want to ask me?

4.3.11 Displaying emotion

In two of the consultations patients displayed emotion through crying. The pharmacist allowed them to show these significant emotions, gave the patient some tissues and provided reassurance.

4.3.12 Ability to relate – common experiences

During most of the interactions the pharmacist and patient touched upon common experiences or interest. On these occasions the pharmacist was able to draw on their own

personal experiences in order to encourage and reassure the patients. These included issues related to dental problems (PT4), interest in an author (PT5), the difficulty of getting up each morning (PT6), research into family history and the ability to maintain a tidy work environment (PT7), the exam process at University (PT8), issues with weight and diet (PT9) and the ability to remember tasks between each meeting (PT11):

- PT4 *I never thought I used to but it's like, clenching my teeth as well I thought as I'm trying to get to sleep I suddenly realise that I was actually clenching my teeth like nobody's business so....*
- PHARM *Ah*
- PT4 *I thought that was something you'd always had*
- PHARM *No, I don't think that's necessarily*
- PT4 *Might account for the decimation of my teeth since I moved to Cardiff*
- PHARM *I wear this really hard acrylic hm it's like a shield, like a gum shield*
- PT4 *Yeah*
- PHARM *but its hard acrylic. That stops your teeth, cause the trouble is the enamel actually wears down*
- PT6 *I just can't grow up at all though, be more independent*
- PHARM *well you are quite independent, you live on your own*
- PT6 *yeah*
- PHARM *you know you work you know*
- PT6 *yeah*
- PHARM *I mean you know if my husband goes away and isn't at home I actually get my mother to ring me in the morning to get me out of bed*
- PT6 *(laughing)*
- PHARM *now that's not particularly independent*
- PT6 *that's good then*

4.3.13 Closing – supply and future interactions

At the end of all the consultations (apart from PT2 due to the identification of a potentially serious side effect) the pharmacist secured a further supply of medication for the patient and arranged the next appointment at a time that suited them.

4.3.14 Non-verbal interaction

The researcher noted that during all of the interactions engaging non-verbal communication was demonstrated throughout by the pharmacist. This included maintaining eye contact, words such as 'yes' and 'mm' to encourage the patient to communicate, nodding and leaning forward in order to appear interested. At no time did the pharmacist take on any negative or defensive behaviour.

4.3.15 Researcher presence

Within some consultations comments either by the pharmacist or patient were directed at the researcher. For example:

- PT1 *I'd like to know where you know the thing of like getting up and going to work, sometimes I think I want that so bad just like you or the lady by there (referring to researcher)*

PHARM (PT2) *PT2 has many allergies [referring to researcher, placing the side effect they had experienced into context]*

PHARM (PT4) *Is that [tremor] because you're particularly stressed at the moment because [researcher]'s sat in the corner or is that how it is?*

This highlights that the presence of a third party could indeed have affected or influenced the manner in which the consultation was conducted.

4.4 Stage Two: Patient interviews post-consultation

Immediately following the consultations an interview was conducted either in the same room as the appointment or another consultation room in the clinic. The interviews lasted from 11 to 38 minutes. Common themes to emerge from the interviews are described below with an illustrative quote.

4.4.1 The pharmacist-patient relationship

Patients described how the pharmacist's personality was paramount in order to form a meaningful relationship. This was thought, by some to be even more important for patients with mental health issues:

PT1 *you've gotto be a certain type of person who can make somebody with mental health issues and prescribing their drugs at ease and be able to express how you feel.*

However, the pharmacist's knowledge of the treatment and condition is also important:

PT2 *I think probably is because she's a pharmacist but also I think I get the impression that she's a very conscientious person, so I think it's sort of a combination of she knows what she's doing because of her training but then her personality comes through as well*

PT12 *she seems to uh know a lot more about medication than the psychiatrist I've seen in the past so um I think it um its really helpful, it's really reassuring um because um [pharmacist] doesn't ever seem to go to look at the little book [BNF] while um a lot of psychiatrists seem to kind of need to look*

Patients felt comfortable in their consultation with the pharmacist. This relationship, or bond, as some patients described it, is developed over a period of time when the care provided is from a consistent source:

PT8 *um I feel quite comfortable talking to her [pharmacist] we're quite chatty and um she's always been very sort of open and friendly so it's not sort of stuffy kind of you know ticking boxes sometimes because sometimes when you can feel like people are just ticking boxes on you and sort of pigeon holing you and stuff like*

PT12 *she's [pharmacist] very easy to talk to and it's in many ways it's easier than speaking to your doctor because um um in that you can kind of because you've got to feel like she's an expert specifically in um medication*

PT10 *well she's [pharmacist] obviously um she gets to know each patient cos I mean it's not like I meet her every 4 weeks and she has to remind herself*

.... as you noticed we talk about general things so she's she'll remember something about I've mentioned before that's just to do with my general life conditions if you like but again that's down to personality isn't it

In addition, patients felt that the pharmacist listened to what they had to say regarding their condition and treatment:

PT2 Yeah yeah, I do feel that she listens to me. Um, like she [pharmacist] understands that I don't want to always want to be trying new drugs and stuff cause I've been on so many different things.

PT6 She [pharmacist] just like a relaxed attitude, the way she talks to you um she listens you know and she gives you time rather than her just sort of going you know blah blah blah, this is that so I I feel more at ease and I think she's more of an open person to speak to

PT9 um I would say very well um you know I felt like I was listened to she didn't sort of cos sometimes in the past when I've seen maybe not her [pharmacist] but like a doctor I, some of the ideas have been like not listened to or dismissed that sort of thing so I feel she listens quite well

Patients suggested that the decisions and discussions regarding their treatment were made in more of an agreement or in partnership with the pharmacist; more of a patient centred approach:

PT1 It is definitely a two way partnership thing and I can feel I can ask [pharmacist] about anything, regarding drugs, about how I feel, or the Bipolar.

PT5 I think you know generally the [centre] they do try to do quite a patient orientated approach towards um all the care and at the end of the day my feeling is that that is the best way because if you push something on to a patient then you you take their responsibility away from them them you know they don't want to do it they're not going to do it

PT5 Whereas if you say how do you feel about this do you want to go up [dose] do you want to take them off [medication] you know it's not the 'I'm the professional I'm telling you what to do'.....you know it's lets discuss this this together so I I think that's that's the best approach

One patient (PT9) felt very lucky to have the opportunity to work with the pharmacist:

PT9 I am you know really pleased I and a few people have said you're really fortunate to have a pharmacist to do that that because I think some people with, in some of the groups, when I've been discussing you know seeing [pharmacist] they've kind of like you know almost been jealous you know

4.4.2 Comparison to other HCPs

Many of the patients compared their relationship with the pharmacist to that of other HCPs they had encountered, such as psychiatrists. Their reflections on these relationships were not as positive. Comments included that patients felt more comfortable with the pharmacist (PT6), the pharmacist related to them differently (PT9), they trusted their knowledge on medication more (PT2) and the pharmacist had been more of a consistent presence in their care (PT7):

- PT6 *she's [pharmacist] easy to talk to, more comfortable to sit with kind of thing than [doctor] to be honest. She's like very relaxed and laid back um you can open up to her more*
- PT9 *I do feel grateful really grateful to be able to see a pharmacist cause not everybody is in that position and it has made, you know it's it's really important cos I, the way she approaches things and the way she relates to me it is it is quite different to a doctor you know and I think it's really important and I, I don't know whether this is happening but I think they should be paid more for it (laughing) because I do feel she is like active you know like she's she doing the duties of a doctor and she's a pharmacist*
- PT2 *I trust what she [pharmacist] has to say about um drugs more than I would a doctor.....because I think she's more knowledgeable..... in terms of drugs and what they do and how they work, I think she knows more than a doctor would.*
- PT7 *Something that used to be a pain was that the doctors changed for ever and I cant remember how many doctors assured me no, they were going to be here and then they went they we're all lovely people and um ...I eventually got to the point where I didn't actually want to invest anything in them but then the [doctor] said she was going to be permanent I believed her fortunately because so far she is*

Patients, as noted above felt that the relationship with the pharmacist was a two way process, a partnership. This is in contrast to that experienced with other HCPs:

- PT9 *we chose it [medication] together which is another good thing that I like about seeing [pharmacist] you know because of the side effects, there's very little side effects.....with the doctor it tends to be, mainly because I dunno you know a psychiatrist is a doctor and you know and people tend to put doctors on pedestals sort of thing and I I tend to be more listened to by [pharmacist] than doctor the doctor kind of tells me you know the way things should be I do feel it is it is different with the pharmacist, I tend to, I feel more listened to and you know she sort of takes on my ideas*
- PT8 *She's [pharmacist] always made it clear why she's asking things and, its quite nice cos sometimes when I've been given medication before it hasn't been very transparent, they just kind of like with sometimes with with the psychiatrists who are brilliant I've had before I came to the centre they sort of just give it to you and they kind of just give you a list of side effects and off you go*
- PT12 *I think so often you can have that kind of feel like a psychiatrist is in control of you or you know that what they say it's kind of over ruling but yeh it's a lot more of a feel that she's giving she's helping you in things like that um go where you want to go*

From experience, some patients commented that the pharmacist does not change the patient's medication as readily as other HCPs, taking into account the patient's views and utilising their knowledge of medication:

- PT4 *I think she's [pharmacist] a lot more careful than the doctor I've actually had, yes. You can tell. When it comes to, in terms of half lives and things like that, I think pharmacist have a much greater understanding of that than doctors do. Doctors will be right that didn't work, let's try this, whereas pharmacist do it very slower and may be try a little bit*

of this and little bit of that. It's a much longer process but its a lot less painful one so..Yeah so pharmacists do definitively have the edge on that.

4.4.3 Time allowed for the consultation

All of the patients felt that an appropriate amount of time was provided for the consultation, which is not always the case with other HCPs:

PT7 one of the nice things about coming in with a change of problem and talking to [pharmacist] is that we have time to go through it properly whereas I have a feeling if I go to my GP he's watching his watch

PT2 That's something that I really notice is that it doesn't at all seem rushed and I think the last time I was here before we started Lamotrigine I actually put my coat on because I felt like I'd been here too long and I had taken up too much of her time.

4.4.4 The pharmacist's role in the consultation

The patients commented on what it was the pharmacist did during the consultation. This included:

- Answering any questions the patient might have, which may not be answered by other HCPs:

PT8 she can answer a lot of the questions for me cos you know I think sometimes especially like GPs and stuff cause it's not their sort of specialism and stuff don't always answer everything for you but I think good thing about pharmacists is they know everything about

- Providing patients with information:

PT2 So that's definitely sort of something that I associate with her [pharmacist] is getting a lot of information.

- Gathering information from the patient in order to assess their progress in relation to medication and their daily lives:

PT4 she [pharmacist] does sometimes ask me things that I'm not sure if they matter but I guess they do about what's being going on. She's more interested in what's being going on with my week than a lot of other peopleI guess it's her way of measuring mood and motivation and ticking off a bit of the checklist in the head sort of thing.

PT9 about it but also she sort of, I don't mind being sort of asked the questions cos I sort of know where she's [pharmacist] sort of coming from with it because we've had the conversations before so I know why she's asking things. She's always made it clear why she's asking things

4.5 Stage Three: Diary completion

Seven patients completed diaries during stage three. The number of entries per participant ranged from four to 44. The entries were brief and mostly fell into a number of broad categories. The categories of entries supplied and an example are provided below:

- A further consultation they had had with the pharmacist since stage one

PT2 Appointment with [pharmacist]. Checked rash, side effects and asked if I wanted to carry on. Had longer two month type appointment.

- Issues related to the supply of medication

PT6 Only given enough tablets for just under two weeks when next appointment is in a month. This often happens when appointments are every other week. Only get enough for a week so have to keep returning for the rest.

- An occasion where the pharmacist and patient had made a decision together such as a change in therapy

PT5 I had an appointment with my pharmacist – we chatted for 30 mins about my mood, sleep, eating etc. It was a really good session, she listened to what I had to say and we agreed to increase the dose of my meds.

- Whether the patient had been taking their medication as intended

PT9 Forgot to take tablets at 10pm. Did not take them at all tonight. (I have had problems recently with adhering to my medication regime even though I have discussed this with my pharmacist).

- The availability of the pharmacist to maintain contact outside of a consultation such as over the telephone

PT2 [pharmacist] phoned me as she said she would. Explained what the doctor said and gave me the choice to proceed or not. Remembered I was at my parent's house and made arrangements for tablets to be delivered to pharmacy nearer their house.

- Issues the patient had intended to discuss with the pharmacist at their next appointment such as their mood

PT8 Having a very down day, will discuss how I feel with pharmacist next time.

- Satisfaction or otherwise with the service or therapy

PT8 Saw pharmacist today, all went well, meds have been really helping and we discussed all possible issues / complications and all is ok. Feel quite relaxed about meds ok to increase dosage of one of meds.

- Patient general feelings such as their mood

PT1 Tearful flat didn't go to [appointment] couldn't face going today.

- Arrangement of a further appointment

PT8 Looking forward to seeing pharmacist on Tues to discuss progress.

These entries were used as a means to aid discussion in stage four which is described below.

4.6 Stage Four: Diary follow-up interview and SIMS questionnaire

Before the final interview began patients were asked to complete the SIMS questionnaire. The total scores ranged from 11 to 16. The categories where an answer of 'none received', 'too little' or 'too much' (0 score) was given is shown below along with the frequencies (Table 4.4).

Table 4.4. Items on the SIMS questionnaire that received a score of 0.

Category	Frequency of 0 score*
How the medication works	2
How you can tell the medication is working	2
How long you need to be on the medicine	1 (not answered)
	1
	2 (not answered)
How to get a further supply	2
What you should do if you experience unwanted side effects	1
Whether you can drink alcohol whilst taking this medicine	2
Whether the medicine will interfere with other medicines	2
	1 (not answered)
Whether the medication will affect your sex life	4
	1 (not answered)
What you should do if you forget to take a dose	1

* A zero score was attributed when participants gave an answer of 'none received', 'too little' or 'too much' information provided by the pharmacist.

The SIMS can be further divided into 2 areas. These areas are “Action and usage of medicines” (items 0-9) which received a score of 6-9 and “Potential problems of medication” (items 10-17) which received a score of 5-7.

Out of the eight patients who participated in stage four, four interviews were conducted after a further appointment with the SP and four were conducted at the researcher’s place of work. The interviews lasted from 18 to 41 minutes. The themes that emerged from these interviews were similar to those expressed in the interviews in stage two. Patients discussed their relationship with the pharmacist and how that compared to previous experiences of being cared for by other HCPs.

4.6.1 Patient satisfaction

All of the patients expressed satisfaction with the pharmacist prescriber service in a similar manner to that expressed in stage two. The amount of information being provided, the pharmacist’s ability to listen to the patient’s views and their ability to engage with the decision making process was seen as positive aspect of their relationship:

PT6 She’s [pharmacist]very informative about you know she she goes into detail about everything which is good instead of just tablets just being thrown at you

PT2 like I have a lot of choices, [pharmacist] doesn’t tell me what to do, she kind of gives me choices about what I could do um it’s very kind of co-operative

PT5 I feel very much that [pharmacist] listens to me and if I go in there and say look I’ve had a bit, this has been bad or this has been good or I want to go up or I want to stay that she listens to me and she respects that

PT10 first of all I’m involved, she [pharmacist] involves you in the whole thing so it’s not a case of uh how are you, scores you from 10 well come back in another months time it’s

how do you feel do you want to carry on with the treatment even if even if it's only um platitudes it makes you feel involved

As expressed in stage two, this is in contrast to previous relationships with other HCPs such as psychiatrists or doctors:

PT8 it felt a little bit more interactive cos sometimes I did feel not to diss doctors they are a little bit more kind of you have to take it like this and you're going to take it like this and then you'll come back in a while and see if it's all ok kind of thing whereas it was more progressive if you know what I mean

PT4 Hm, seems to be quite good actually cause she does give me a lot more information about the actual drugs themselves than the doctor ever did. So, she seems to know a greater variety and be a lot more up to date on all of them.

PT10 psychiatrists seem to say nothing just oh yes right mmm yes well take those and come back in a month's time and um again a psychiatrist I saw then was very kind of um I don't think he even spoke 2 words um in the interview

Before the pharmacist began prescribing for them, there was little awareness amongst the patients regarding pharmacist prescribing. One patient (PT8) was surprised that they previously could not prescribe:

PT8 I always found it quite surprising that pharmacists didn't have more of uh you know couldn't sort of do anything to do with the meds apart from sort of dispense them and maybe talk to you a bit about them you know

4.6.2 Consistency of care

As described above, a major theme was that patients were appreciative of seeing a HCP consistently. This consistency allows the HCP to monitor their condition to a greater extent (especially if a dose is being modified), to tailor the medication to the individual and allows the patient to have a regular time to ask questions and discuss their condition. In addition, seeing the same person avoids repeating their 'story' each time they meet a new HCP:

PT4 I'm just grateful to be seeing someone consistently.

PT5 you get to see [pharmacist] in theory every other week whereas the psychiatrist you get to see about every 3 months you

PT9 well one reason why I've stayed with the pharmacist for such a long time was because what I was finding with the psychiatrist, I was seeing him not very frequently

PT10 its more to do with um feeling, having support because again within sort of mental health side of um of the the health service there's a reputation of not much support or sometimes not much support its very spotty if you like so I appreciate, I've appreciated especially even it's the the moral support of seeing [pharmacist] once a month because it, something's happening

4.6.3 Pharmacist accessibility

As well as seeing a HCP consistently patients appreciated the accessibility of the pharmacist. The SP was believed to be easier to access compared to a psychiatrist. As mentioned in

previous stages, patients were given the option of contacting the SP beyond the immediate face-to-face consultation, either via email or telephone:

PT5 mmm and I think also I can get hold of her [pharmacist]..... and I will be able to speak to her directly whereas with a psychiatrist you would struggle to do that or they'd probably leave a message and they might ring you in three days time

PT9 I if I had a problem if I was just seeing the doctor and I had a problem I know I wouldn't be able to get in contact with him the way I can with the pharmacist I couldn't just ring him up cos he's just too busy

4.6.4 Pharmacist knowledge

Patients acknowledged that pharmacists have a high degree of knowledge regarding medication which has contributed to patients' confidence in the pharmacist's role:

PT6 From my point of view I think she seems more knowledgeable and she explains a lot more about the tablets and what's happening

PT8 um well I've always been surprised by the fact that pharmacist actually couldn't [prescribe] cos obviously they know the most about drugs out of anyone

PT1 And I said I'm more than happy for her to do that because I trust her and her knowledge, she's a pharmacist,

PT2 I feel you get more specialist knowledge from a pharmacist

4.6.5 The issue of mental health

Patients discussed how relaxed and able they were to discuss issues freely in their consultation, in the same manner as stage two. However, some patients believed that there should be a difference in approach to the care provided as a mental health illness is being treated rather than a physical one. A suggested reason for this was due to the sensitive nature of the area and that medication is often approached on a 'trial and error' or 'guinea pig' basis. Patients cannot take a 'magic bullet' (PT8) to cure their condition and medication needs to be tailored to the individual. A couple of patients also mentioned that they are more at ease because the pharmacist does not have the ability to section them.

PT1 My own personal opinion is I think it's a really good thing but I do think that it has got to be that patient and pharmacist knowing each other. Not signing, just signing prescriptions in mental health care because you can't just um, like when you go and see your GP you say you're depressed. I think when it's at this stage there needs to be a bit more aware of the client that you're dealing with and the mental health that they're suffering from

PT5 um but in terms of say the GP doing it like I would prefer to come here and see [pharmacist] than do it with the GP because [pharmacist] understands all the mental health stuff and some GP's they don't really get it or they don't believe in it or whatever

4.6.6 Negative comments

Any negative comments expressed by the participants were few and far between. The only ones mentioned concerned:

- Issues related to collection of medication. On a small number of occasions patient's medication was not ready to be collected.
- Ensuring that the pharmacist has an appropriate place to conduct the consultations as, at times the SP did not have a designated area to work within the clinic or hospital department.

4.7 The patient journey

Seven of the participants took part in both interviews in stages two and four, six completed the diary. On reviewing the data it is clear that patient views had not changed between the interviews. This was over a period of at least six weeks. Patients were still positive regarding their experience of consulting with their pharmacist and the perceived benefits. Many of the patients were acutely aware of the differences between their current experiences of care in comparison to that provided by other HCPs / services.

Conclusion

This chapter has described in detail the themes that have emerged from both the observation and interviews. The final chapter will discuss these results within the context of the wider literature.

Chapter 5: Discussion

Eleven patients participated in the study. The consultation highlighted the rapport which had developed with the pharmacist over a period of time and the two way nature of the dialogue. All patients expressed a positive view on the consultation and the service provided by the SP in their interviews. Participants highlighted how the pharmacist was more consistent in their care and listened to their views in order to ensure decisions were made in partnership. This was in contrast to their prior experiences.

5.1 The consultation

The consultation is a very important communication event where the interaction between the patient and the HCP is used as a means to make decisions regarding treatment options and the care of the patient. The medical consultation can take many forms. Charles *et al.* (1999) differentiate between three types of consultation. In the 'paternalistic model' information is passed from the HCP to the patient. In this model the patient passively accepts the information and decisions, there is no shared decision making. In the 'shared model' information is provided from both the HCP and patient, there is a free exchange of information and the HCP and patient agree on a treatment option. Finally, in the 'informed model' the HCP provides the patient with sufficient information to allow them to make their own decision about which treatment option to adopt.

The form of the encounter, for example, whether it is 'patient-centred' (Tawab *et al.*, 2005) or not can impact on the outcome of the consultation for the patient and how adherent they are to their medication. A patient-centred approach is important to engage with pharmaceutical care. Consultation models have previously been utilised to a great extent within medical education. In contrast, pharmacy and its education system have traditionally focused on communication skills (Hargie *et al.*, 2000) such as non-verbal communication, questioning and listening. However, with the advent of new roles such medicines use reviews and prescribing as described here it has been acknowledged that pharmacists are in need of developing more consultation skills.

There are a number of consultation skills tools available, mainly focusing on the interaction between medical practitioners and patients. These include, for example, the SEGUE framework (Makoul, 2001) and the Henbest and Stewart framework (Henbest and Stewart, 1989). The SEGUE framework has been developed to assist in the teaching and assessment of communication skills within the medical profession and is used to review the content of the interaction against validated criteria. In contrast, the Henbest and Stewart framework was developed in the medical encounter to assess how 'patient-centred' an interaction is. Research suggests that when HCPs adopt this approach and try to understand those issues and the views presented, patients may be more satisfied. 'Patient-centredness' is therefore paramount (Henbest and Stewart, 1990) as opposed to the more practitioner based interaction. Little and colleagues (2001) conducted a study in primary care regarding patients' preference for a patient-centred interaction. Interestingly, they found that patients with psychosocial problems were more likely to prefer this shared type of interaction.

Other consultation frameworks which have been developed within the medical field include the 'Model of patient-centred care', the 'Pendleton consultation model' and the 'DREAM

consultation model'. Many of these frameworks incorporate aspects of patient-centred care but do not directly apply to the pharmacy or indeed the mental health setting.

A number of studies have investigated pharmacist-patient interactions. Hargie and colleagues (2000) investigated communication within the community pharmacy in order to identify key elements of effective communication skills. Morrow *et al.* (1993) concentrated on a more quantitative approach to investigate the number of questions asked by the pharmacist and patient during a consultation. However, neither of these studies concentrated on the two-way nature of the dialogue and the more 'consultative' interaction between the pharmacist and patient.

Greenwood and colleagues (2006) reviewed the transcribed recordings of pharmacist-patient interactions and applied the previously validated consultation models (SEGUE and Henbest and Stewart) in order to establish whether they could be applied to pharmacist-patient consultations. In contrast to this study, these patients were suffering from heart failure and the consultations took place in the patient's home. Furthermore, the researcher was not present at the time of the consultation. Although Greenwood (2006) concluded that they could be applied, not all of the criteria or the frameworks in the medical profession are freely applicable to pharmacy. For example, in SEGUE, one criterion focuses on discussing diagnostic procedures with patients, but pharmacists were not proficient in this area of care.

The Calgary Cambridge model (Kurtz and Silverman 1996 and Kurtz *et al.*, 2003) also outlines important elements of the consultation and is often used in training non-medical prescribers (Sodha and Dhillon, 2009). It details the importance of establishing a rapport with patients, involving the patient in the interaction and listening actively. The tool was developed initially with the aim of training medical prescribers, however, it does share common attributes with the consultations discussed in this present study.

Stewart and colleagues (2010b) have developed the Pharmacist Consultation Assessment Tool (PharmaCAT) (modified from the Royal College of General Practitioners consultation tool). This was based on a small purposive sample of prescribing pharmacists, however, none of the participants were prescribing within the area of mental health. This study also had an additional focus on the non-verbal interaction as consultations were video recorded.

The Medication-Related Consultation Framework (MRCF) (Tawab *et al.*, 2005), is a tool developed specifically for the pharmacist-patient consultation. It also employs a patient centred agenda and involves the pharmacist actively listening and taking into account the patient's views of their medication and condition. The framework consists of 46 key skills which have been divided into five criteria, namely, introduction, data collection and problem identification, actions and solutions, closing and consultation behaviours. These criteria encompass similar concepts to the SEGUE (Greenwood, 2006). The characteristics of the consultations in this study when reviewed in relation to the criteria in the MRCF and Calgary Cambridge model and SEGUE illustrate some areas of similarity and contrast.

The pharmacist in this study greeted the patient on each occasion. This may not have been recorded as it often took place prior to the patient being introduced to the researcher, for example in the patient waiting room. The MRCF specifies that the pharmacist introduces themselves and identifies the patient. There is no need for this element as they had previously met on numerous occasions. The frameworks also suggest discussing the purpose of the meeting. It may be argued that the pharmacist had not demonstrated this element,

however, this is not the first meeting and therefore these aspects could have been discussed previously. In addition, patients agreed that, in general, these meetings were reflective of their 'usual' encounters and therefore they knew what to expect. Interestingly, the SEGUE framework mentions 'making a personal connection during the visit' which was demonstrated when the pharmacist and patient were able to share common interests and move beyond that of medication and therapy. All of the consultations ensured privacy as they were held in an office or designated consultation room.

The three frameworks specify the collection of data or information during the consultation. The pharmacist in this study was indeed collecting data and identifying problems as can be seen from their questioning skills. However, some aspects of this criterion in the MRCF focus on adherence assessment and taking a full medication history. This is not relevant to this study as the pharmacist knew the patient's medication history and, as mentioned previously the focus was not on the medication. In contrast, the SEGUE framework includes some more non-medication orientated criteria. These include exploring psychosocial and emotional factors such as living arrangements and family which is clearly seen in these consultations. The frameworks also encourage discussing the patient's views of their health and allowing involvement in the decision making process. Patients were given the opportunity to ask questions, to express their views and have input into decision making. It was evident in each consultation that any decision was made with the patient being fully informed and in agreement. Indeed, the interviews illustrate how the patients appreciated having an input into the decision making - the pharmacist 'listened to what I had to say'.

Another important element in these frameworks was providing information and solving problems. Any changes suggested by the pharmacist were explained and justified to the patient. However, in some cases, as the plan to change any medication had been previously agreed between both parties it was not possible to ascertain how this was brought about. These are regular meetings, often with long term goals (e.g. an end point of tailoring the patient's medication to the correct dose over a long period of time). The changes seen in these current consultations may not therefore reflect the total amount of information provided and in which format.

On closing, HCPs are encouraged to make a further appointment and to allow contact time between appointments (MRCF) which was seen in this study. The Calgary Cambridge model specifically highlights forward planning which was addressed at the end of each appointment. In addition, patients were encouraged to ask questions as reflected in both frameworks. The pharmacist's manner is also assessed, such as their ability to listen attentively, to use appropriate non-verbal communication skills and the use of appropriate questions and empathy. It could be argued that these general behaviours may be applied to any consultation.

As seen above there are a number of areas within the MRCF, SEGUE and Calgary-Cambridge frameworks which freely translate to the consultations in this study. However, the MRCF focuses on consultations with patients about their medicines and the SEGUE and Calgary-Cambridge were initially designed for use with general practitioners in their surgery. These are very different scenarios and are therefore not wholly applicable to this study and patient group. Importantly, there is not a tool specific to mental health, nor for pharmacists working in mental health. Importantly, mental health encompasses a more holistic approach

as demonstrated in this study. In addition, the extended role of the pharmacist to prescribing will inevitably move their focus beyond that of medication. The consultations do not solely focus on medication and issues such as mood, sleep and appetite alongside non-pharmacological interventions are all discussed in order to gain an insight into the patient's overall well-being. A number of participants acknowledged that the manner in which a HCP approaches the patient is different in mental health compared to that of a physical illness and therefore a framework to reflect such an approach would be worthwhile.

The rapport, between the HCP and patient is paramount (as seen in the Calgary-Cambridge model) for there to be a level of trust and partnership. Some patients highlight that it is only this one participating pharmacist they can comment on, not pharmacist prescribing as a general concept. This is because it is the specific personality of the individual HCP that 'makes' the relationship. Placing the constraint of a framework may not therefore be truly appropriate as each interaction is tailored to the individual. This highlights that frameworks are useful as a generalist consultation tool but may not be truly applicable to specific situations such as the one in this study.

5.2 Conditions being treated

Many of the patients were being treated for bipolar disorder. The aim of this study was not to assess the appropriateness of the treatment, however, the National Institute for Health and Clinical Excellence (NICE) (NICE, 2006) guidelines on this condition does draw attention to some aspects of the consultation. Importantly, 'HCPs should establish and maintain collaborative relationships with patients and their families and carers, be respectful of the patient's knowledge and experience of the illness, and provide relevant information at every stage of the assessment, diagnosis and treatment' (p10). In addition, lifestyle (such as sleep and daily life) is highlighted as an important aspect of the patient's monitoring along with the involvement of family. All of these aspects were frequently discussed in the consultations.

Many of the patients were having the dose of their medication individually tailored over a period of time as is frequently the case in mental health in order to assess side effects and tolerance (NICE, 2006). One of the most frequently used was lamotrigine where a gradual increase in dose is essential to avoid potentially serious skin rashes. This was highlighted in one consultation where a skin rash was identified and the interaction took a different course compared to the other participants.

5.3 Patient satisfaction

All of the patients expressed positive views regarding the service provided by the pharmacist. Other small scale studies have also reported a high degree of patient satisfaction (Smalley, 2006 and Stewart *et al.*, 2008). Stewart and colleagues (2008) conducted a small quantitative study and explored patients' views with a number of different conditions, albeit, not within the area of mental health. The majority of patients agreed that the pharmacist provided them with information regarding their condition and that the 'pharmacist prescriber was interested in me as a person, not just my illness'. These results have been reflected in this current study. However, in contrast, those patients surveyed in Scotland (Stewart *et al.*, 2008) would see a doctor if they had the choice as opposed to the pharmacist prescriber. Smalley (2006) surveyed patients in a pharmacist prescribing hypertension clinic. Satisfaction was demonstrated. However, those participating were mainly patients who continued to attend the clinic and one might therefore predict that they may have positive views of the service.

5.4 SIMS score

The item on the SIMS score which received the greatest number of '0' scores was 'Whether the medication will affect your sex life'. This correlates with the results obtained with other bipolar patients (Bowskill *et al.*, 2007). However, Bowskill and colleagues report that they were unable to determine the reason for the dissatisfaction in their study group. The patients in this present study allocated a score of 0 to only a small number of issues (minimum score was 11). It was not possible to determine the exact information that had been previously provided, however, patients reported that they did feel comfortable asking for further information should they require it.

5.5 Perceived benefits of pharmacist prescribing

Predicted benefits of non-medical prescribing were increased access, greater consistency of care and greater patient involvement in their health (MCA and DoH 2002). The patients described how seeing their pharmacist prescriber allowed them to access a HCP more frequently. Indeed, numerous occasions were described where the pharmacist could be or was contacted beyond the face-to-face meetings. The importance of this accessibility is highlighted by NICE (2006) who state 'a co-ordinated care programme, with rapid access to support at times of crisis, is essential' (p33). In addition to access, the consistency of care was thought to have improved which is seen to be important by NICE (NICE, 2006) in order to improve patient outcomes.

Patients in both interviews compared their experiences with the pharmacist prescriber to that of other HCPs. They explained that more regular meetings were organised and should they have a question or were concerned it would be easier to access the pharmacist compared to their psychiatrist, for example. The pharmacist was also seen to engage with the patient more and take on board the patient's wishes.

All patients believed that the pharmacist provided an appropriate degree of information which can be seen from the SIMS scores. They also created a 'friendly and relaxed' atmosphere and answered any questions the patients had. This was thought to be important in mental health due to the potential for side effects from medication. Some of the patients explained that previous HCPs had not informed them of these side effects, they had been told to take their medication, to try them and see if they worked, to act as 'guinea pig' as PT6 explains.

5.6 Methods and limitations

A multi-method case study approach was adopted in this present study including semi-structured interviews, non-participant observation and the diary: diary follow-up interview method, methods adopted elsewhere in research on supplementary prescribing. For example, a case study approach including semi-structured interviews and observation has also been utilised to investigate how supplementary prescribing has worked in practice (Weiss, 2005). Importantly, patients expressed their views over a period of approximately seven weeks. This longitudinal approach allowed participants to reflect on the service and their experiences with their SP. This is in contrast to a snap shot approach where views are only captured at a single time point. As a result the positive views expressed by participants indicate consistent delivery of care throughout the study period.

The manner in which the patients were selected to participate by the pharmacists could have introduced some selection bias into the study. Patients with only positive views or especially motivated individuals could have been targeted. In addition, this is only a small scale

purposively selected study. The results are only valid for this particular setting and cannot therefore be extrapolated further.

It is important to acknowledge that the participants, both patients and pharmacist may have been affected by the presence of the researcher while they were being observed, known as the Hawthorne effect (Savage, 1996). During the observations it was clear that participants were aware of the researcher's presence. On a number of occasions reference was made to, comments directed at and questions asked of the researcher. It is impossible to know to what extent participants were affected. In addition, the consultations were not video recorded and therefore detail of the non-verbal interaction was not possible, beyond the researcher's notes. However, it was felt that video recording as opposed to audio recording would be more intrusive, especially within the sensitive nature of the mental health setting.

The aim of the second stage of the research was to discuss the particular consultation that had been observed. As can be seen from the results, many of the themes were similar to the more general discussion in stage four. Patients preferred to discuss their experiences more generally instead of focusing on the minutiae of the consultation throughout. This is something to bear in mind should a similar study be carried out.

The entries recorded in the diaries generally reflected the areas discussed in the interviews or observed during the consultations and were used as an aide memoire. Due to the nature of the appointments some patients did not record many entries as they had not seen the pharmacist within the six week period. For this anticipated reason the diaries were flexible to allow the patient to record as much or as little as they wished. Patients were happy to be contacted by the researcher both mid-way and at the end of the diary completion period. However, the degree to which the contact contributed to the participants' motivation to complete entries is unknown.

Patients were provided with payment as an incentive and thank you for their time. These payments were given in stages dependent on what the patient had consented to and after each completed part. The researcher noticed that some participants were awaiting payment while others had forgotten by the time the fee was provided at the end of the interview. This highlights that perhaps the incentive was greater for some compared to others. Cleary and colleagues (2008) discuss the issue of paying 'vulnerable groups' and recognise it as being a controversial issue. Payment was meant to provide an incentive, however, it is impossible to know how it may have affected an individual or the information provided.

5.7 Further research

This current study supports the implementation of pharmacist prescribing within a small number of patients in the area of mental health. However, further, more wide ranging research needs to be undertaken to evaluate the use of pharmacist prescribing. As highlighted in the literature review, many of the studies exploring patient views on non-medical prescribing are on a small scale. This study supports Stewart and colleagues' (2009a) views that there 'remains an urgent need to provide evidence of patient outcomes (economic, clinical and humanistic) of pharmacist prescribing in a large number of patients' (p93).

Chapter 6: Summary and main conclusions

This study has explored the service provided by a pharmacist SP within the mental health setting. It has demonstrated that it has been possible to utilise a multi-method staged approach in order to evaluate and explore patient views on a service.

A number of pharmacist-patient consultations were observed in order to ascertain what happens in such an interaction. The results demonstrated that the consultations follow a consistent pattern where the pharmacist collected information and took action to solve any issues that arose. Importantly, any changes to therapy were made in agreement with the patient. On reviewing the consultation model literature it is evident that many aspects of other, established frameworks may be applied to these situations. However, a framework suitable for both prescribing pharmacists and the mental health setting is lacking.

Interviews were conducted both after the observed consultation and as a follow-up approximately six weeks later. These interviews demonstrated that the patients were satisfied with both the consultation and the service as a whole. They compared the service with the care provided previously by other HCPs and stated that the consistency and accessibility of care was improved. Patients were given enough opportunity to ask questions and input into the decision making process. It is encouraging that the positive views of the patients reflect the predicted benefits of non-medical prescribing at its inception.

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Appendices

The research data collection tools are provided in the following appendices.

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Appendix 1

August 2007 Ver 1

Patient Demographic Information

Participant identification number:

Please fill in the following sections by ticking the relevant boxes or noting the appropriate information:

1) Age

18 – 29 30 – 39 40 – 49 50 – 59

60 – 69 70 – 79 80 +

2) Gender Female Male

3) Ethnicity Caucasian Non-Caucasian

4) First language

5) Languages that the patient is fluent in

.....

6) Condition treated by pharmacist (as per CMP)

7) Co-morbidities (please list)

.....

.....

.....

8) Duration of treatment by pharmacist

a) Before supplementary prescribing: Years Months

b) Since supplementary prescribing: Years Months

Appendix 2

August 2007 Ver 1

Stage Two: Post-consultation interview schedule

Opening –

- Good morning / afternoon, thank you for meeting with me today. My name is Rhian and I'm a researcher from Cardiff University.
- As I explained in your information sheet I'm carrying out a project to look at the views of patients (and their carers) on the service that your pharmacist provides.
- Today, I'd like to talk about the appointment that you have just had with the pharmacist. This will let you explain how you feel the appointment went while it's still fresh in your mind.
- Before we start I'd like to ask if you have brought your consent form along with you so that I can also sign it (a spare copy will be provided, if needed). I would also like to check that you are still happy to take part in this interview. If so, are you still happy to have the interview recorded? (Start the tape with consent)
- I'd like to remind you that all of the information we talk about will be kept confidential. It will not be possible to identify who you are from any work that comes out of this project.
- Please feel free to let me know what you really think.
- Is there anything that you would like to ask before we start?

To begin the interview –

I have a short list of questions that I'd like to ask you. If I can just start by asking you to tell me about what happened in the appointment that you have just had with the pharmacist.

Topics –

1. How did you expect the appointment to go beforehand?
2. How far did the appointment meet your expectations?
3. What do you think you got out of today's visit?
4. Were there any topics that you wanted to talk about which you didn't get a chance to?
5. How much opportunity did the pharmacist give you to say what you wanted to?
6. Did you ask the pharmacist any questions?
7. To what extent did the pharmacist answer the questions that you may have had?
8. What are your thoughts on the way the pharmacist talks to you?
9. How well do you think the pharmacist was listening to you?
10. What are your thoughts about the length of time allowed for each meeting you have with the pharmacist?
11. Is there anything that you think the pharmacist could have done differently?

Closure –

- Is there anything else that you would like to talk about before we finish?
- If I could just summarise what we covered in the interview to ensure that I have understood....
- Is there anything else that you would like to add?
- Thank you very much for your time, it is greatly appreciated

Prompts

'Can you tell me a little more about that?'
'Can you explain that in a little more detail?'

'Can you give me an example?'
'What do you think about?'

Patient diary for the evaluation of a pharmacist prescriber service

Participant identification number:

Start date: / / 20.....

End date: / / 20.....

After the end date please return the diary in the envelope provided to:

Rhian E Jones
Welsh School of Pharmacy
Cardiff University
Redwood Building
King Edward VII Avenue
Cardiff
CF10 3NB

How to fill in your diary

Thank you for agreeing to take part in this study by completing a diary of your experiences of being looked after by a pharmacist prescriber.

Here are some points to help you fill in the diary:

- 1) You only need to make an entry about an event or incident to do with:
 - a. the condition(s) being managed by your pharmacist
 - b. the medicines prescribed by your pharmacist
 - c. the service provided by your pharmacist prescriber
- 2) The diary is not to be used to list questions that you would like to ask about your treatment. You should ask your pharmacist these questions. However, you may like to record the fact that you needed to contact the pharmacist about a query.
- 3) You are not required to complete an entry every day.
- 4) For each entry please record:
 - a. The date
 - b. Details of the event or incident
 - c. DO NOT enter any names or locations. The diary should be kept anonymous.
- 5) Fill in a new section for each event or incident.
- 6) Please write the entries as clearly as possible.
- 7) The diary should be completed over six weeks.
- 8) If extra diary sheets are needed then please get in touch with Rhian Jones on the contact details below.
- 9) The researcher will contact you to answer any questions you might have. You will also be contacted after six weeks to remind you to return the diary.
- 10) What will happen to the diary:
 - a. After six weeks the diary should be returned to the researcher in the envelope provided.
 - b. The contents of the diary will be analysed.
 - c. An interview with the researcher will then be held at a convenient time and place. In the interview we will discuss your diary entries and your views on the pharmacist service.

- 11) If you have any questions about the diary and how to complete it, please get in touch.

The researcher can be contacted on the details below:

Rhian E Jones, Welsh School of Pharmacy, Cardiff University, Redwood Building King Edward VII Avenue, Cardiff. CF10 3NB

E-mail: JonesRE4@cardiff.ac.uk

Telephone: 029 20 875810

Week One

Date:
Entry:

Week Two

Date:
Entry:

Week Three

Date:
Entry:

Week Four

Date:
Entry:

Week Five

Date:
Entry:

Week Six

Date:
Entry:

Patient and carer diary for the evaluation of a pharmacist prescriber service

Participant identification number:

Start date: / / 20.....

End date: / / 20.....

After the end date please return the diary in the envelope provided to:

Rhian E Jones
Welsh School of Pharmacy
Cardiff University
Redwood Building
King Edward VII Avenue
Cardiff
CF10 3NB

How to fill in your diary

Thank you for agreeing to take part in this study by completing a diary of your experiences of being looked after by a pharmacist prescriber.

Both patient and carer may make entries. Here are some points to help you fill in the diary:

- 12) You only need to make an entry about an event or incident to do with:
 - a. the condition(s) being managed by your pharmacist
 - b. the medicines prescribed by your pharmacist
 - c. the service provided by your pharmacist prescriber

- 13) The diary is not to be used to list questions that you would like to ask about your treatment. You should ask your pharmacist these questions. However, you may like to record the fact that you needed to contact the pharmacist about a query.

- 14) You are not required to complete an entry every day.

- 15) For each entry please record:
 - a. The date
 - b. Who has written the entry by initialling the entry
 - c. Details of the event or incident
 - d. DO NOT enter any names or locations. The diary should be kept anonymous.

- 16) Fill in a new section for each event or incident.

- 17) Please write the entries as clearly as possible.

- 18) The diary should be completed over six weeks.

- 19) If extra diary sheets are needed then please get in touch with Rhian Jones on the contact details below.

- 20) The researcher will contact you to answer any questions you might have. You will also be contacted after six weeks to remind you to return the diary.

- 21) What will happen to the diary:
 - a. After six weeks the diary should be returned to the researcher in the envelope provided.
 - b. The contents of the diary will be analysed.
 - c. An interview with the researcher will then be held at a convenient time and place. In the interview we will discuss your diary entries and your views on the pharmacist service.

22) If you have any questions about the diary and how to complete it, please get in touch. The researcher can be contacted on the details below:

Rhian Jones, Welsh School of Pharmacy, Cardiff University, Redwood Building, King Edward VII Avenue, Cardiff. CF10 3NB. E-mail: JonesRE4@cardiff.ac.uk Telephone: 029 20 875810

Week One

Date:
Entry:

Week Two

Date:
Entry:

Week Three

Date:
Entry:

Week Four

Date:
Entry:

Week Five

Date:
Entry:

Week Six

Date:
Entry:

Appendix 5

August 2007 Ver 1

Stage Four: Follow-up interview schedule

Opening –

- Good morning / afternoon, thank you for meeting with me today and for taking part in the project. In previous stages (if appropriate) I've sat in on one of your appointments with the pharmacist, we have discussed your views on that appointment and you have completed a diary.
- This is the final part of the project where we will talk about what you think about the pharmacy service as a whole.
- Before we start I would like to check that you are still happy to take part in this stage of the project. Are you still happy for this meeting to be recorded? (Start the tape with consent)
- Firstly, I would like to ask you to complete the Satisfaction with Information about Medicines Scale (SIMS).
- This is a short questionnaire. It asks questions about how happy you are with the information the pharmacist gives to you on the medicines they prescribe.
- I'd like to remind you that all of the information we talk about will be kept confidential. It will not be possible to identify who you are from any work that comes out of this project.
- Please feel free to let me know what you really think.
- Is there anything that you would like to ask before we start?

To begin the interview –

I have a short list of questions that I would like to ask you. If I can just start by asking you to tell me about how the pharmacist came to manage your condition.

Topics –

1. What did you think when you were told that a pharmacist might look after you?
2. What did you know about the role of a pharmacist before you learnt that some could now prescribe medicines?
3. What did you think the job of a pharmacist was?
4. How has your condition been managed since you've started seeing the pharmacist?
5. How well has your condition been controlled since you've been seeing the pharmacist?
6. Have you noticed any changes in your condition since the pharmacist started managing it?
7. What do you think about a pharmacist looking after your condition?
Previous experiences
8. Do you think the pharmacist meets your expectations of someone who looks after your care?
9. How would you describe the way that the pharmacist talks to you when you meet?
10. To what extent does the pharmacist answer any questions that you may have?
11. What information do you think is important for the pharmacist to tell you about?
12. How much of this information do you get told?
13. How much contact do you have with the pharmacist between meetings?
14. How often do you meet with the pharmacist?
15. Could you describe a typical meeting that you have with the pharmacist?

16. How do you usually feel when you leave those meetings?

Closure –

- Are there any other issues that you would like to talk about before we finish?
- If I could just summarise what we covered in the interview to ensure that I have understood....
- Is there anything else that you would like to add?
- Thank you very much for your time, it is greatly appreciated