Pharmacy Practice ℞

Educational Support During the Transition to Pharmaceutical Care Implementation - The Experience of One Department

Lori Blain and Fitzpatrick C. Obilo

BACKGROUND

Prior to 1991, pharmacists at Toronto East General Hospital (TEGH) provided a variety of clinical pharmacy services to patients in all areas. Although there was general acceptance by medical and nursing staff of these traditional services, many pharmacists felt that the potential to improve patient care existed and should be investigated. For example, since there was no uniform approach by pharmacists, there was inconsistent continuity of care when a patient was transferred from one unit to another. Also, patients' health care records were used as the primary source of information rather than the patients themselves.

Upon becoming aware of the philosophy of pharmaceutical care (PC) as proposed by Hepler and Strand[1] the pharmacists collectively considered whether it could provide the basis for the changes that needed to be made. They discussed the fundamentals of PC including its definition, purpose and steps, the latter of which includes the need to develop a covenantal relationship[1] with individual patients. Eventually the pharmacists decided that the philosophy of PC was compatible with what they wanted to practise.

Thus, the task of making the transition from clinical pharmacy services to PC was initiated. More specific details about the actual implementation of PC is published elsewhere.[2] In an effort to learn how to provide PC and maintain the high level of therapeutics knowledge needed to care for patients efficiently and effectively, some additions and modifications were made to the departmental educational support.

ADDITIONS TO EXISTING EDUCATION

Pharmaceutical Care Workshops

Six 1-hour workshops were held to assist pharmacists in understanding how to use available PC-related educational processes and tools. (See Appendix A) These workshops were facilitated over several months by the Clinical Managers and the Coordinator, PC. Each 1-hour session was repeated 3 times to allow an opportunity for all to attend without disrupting workflow and to make the size of each group more conducive to discussion and learning. Between each of the sessions, pharmacists were required to complete an exercise that was based on what was learned in the previous workshop and essential to the discussion of the next workshop.

The process and tools which were used as the basis for learning were the Therapeutic Thought Process (TTP)[3] and the Pharmacists' Management of Drug-Related Problems (PMDRP).[4] These tools are used in the education of undergraduate and PharmD students at the Faculty of Pharmacy, University of Toronto. The TTP is one example of a systematic process for identifying a patient's drug-related problems (DRPs). The PMDRP is used to learn what information to collect regarding a patient, his/her disease(s), medications, and signs and symptoms and how to use this information to identify DRPs and develop a pharmacy care plan for each.

Self-Directed Education Program

The above workshops were adapted to produce a self-directed education program which includes a written didactic component and a cassette tape with additional didactic discussion which complements some segments. This program formed part of the orientation for new pharmacists or those returning from leaves of absence who were not already familiar with the TTP and PMDRP.

The learning manual consists of 5 sections with readings and exercises to complete prior to each. It is estimated that it would take a pharmacist approximately

Lori Blain, BScPhm, was the Pharmaceutical Care Coordinator, Toronto East General Hospital, Toronto, Ontario, and is currently an Educational/Site Coordinator, Faculty of Pharmacy, University of Toronto, Toronto, Ontario.

Fitzpatrick C. Obilo, PharmD, was a Clinical Manager, Toronto East General Hospital, Toronto, Ontario, and is currently a pharmacy consultant in Toronto.

Address Correspondence to: Lori Blain, Educational/Site Coordinator, Faculty of Pharmacy, University of Toronto, 19 Russell Street, Toronto, ON M5S 2S2.

1 to 4 hours to prepare for each session depending on the topic and prior experience of the pharmacist. Actual completion of each session takes approximately 1 hour.

The overall goal of the self-directed program and the workshops discussed above was for the pharmacists to be able to explain what is meant by a covenantal relationship which is essential for the provision of pharmaceutical care,[1] the TTP, and PMDRP. The goal was not that the pharmacists be able to develop covenantal relationships with patients nor use the process and tools efficiently and effectively. This objective was to be realized through the pharmacists' own application of the concepts, coaching by the Coordinator, PC and Clinical Managers, and the formation of PC teams.

Pharmaceutical Care Resource Teams

In the fall of 1993, 4 PC resource teams were developed. The original intent of these teams was to:

- provide support and guidance as pharmacists learned how to apply the PC process to real patients;
- provide an opportunity to share knowledge and experience with colleagues learning how to provide PC to similar types of patients; and
- improve continuity of care between different areas of the hospital.

Each team was led by a resource person, one of the clinical managers or the Coordinator, PC. The primary responsibilities of this person were initially to:

- take a leadership role in integrating PC into their patient practice;
- assist pharmacists in determining their personal goals with respect to learning how to provide PC;
- review completed PMDRPs; and
- provide constructive feedback and support.

Each team met monthly to informally review cases or discuss areas of difficulty in providing PC to patients. Team members encouraged and learned from each other during these discussions. Several of these teams developed templates of the first page of the PMDRP for selected disease states (i.e., unstable angina, diabetes mellitus, MI), or categories of patients (i.e., paediatrics, geriatrics) which could be shared amongst teams. Some teams developed therapeutic alternative charts for sharing. Each team was encouraged to log their activities so that other individuals or teams could review them for their own benefit.

The PC resource teams played a role in the transition from providing clinical pharmacy services to PC, but were disbanded in the fall of 1994 as part of departmental reorganization.

Coaching

While the PC resource teams were in place, the Coordinator, PC and the Clinical Managers each had responsibilities for coaching staff pharmacists as they learned to provide all steps within the PC process. In addition to their other administrative and clinical responsibilities, the Clinical Managers were responsible for periodically coaching individual pharmacists within their PC resource team. The Coordinator, PC was responsible for coaching pharmacists on the team but also for coaching each pharmacist on staff. The latter was accomplished by having the Coordinator, PC provide PC to a few patients on the staff pharmacist's nursing unit during the week when he/she was to coach that particular pharmacist. The pharmacist was responsible for providing full PC to at least 1 patient during that week; other patients continued to receive usual clinical pharmacy services. The pharmacist and the Coordinator, PC then met to discuss the patients for whom they had given care. From this discussion, a summary of the PC-related learning issues for the individual pharmacist and of actual or potential challenges in the integration of PC on that particular nursing unit was developed. A copy of this summary was provided to each pharmacist and the relevant Clinical Manager.

After the fall of 1994, coaching was provided on an as needed basis, usually at least once every 2 months.

Pharmaceutical Care Committee

A PC Committee was formed in October 1993 with the purpose of developing proposals pertaining to the practice and education of PC at TEGH. It was found that this committee played an integral role in many issues that facilitated pharmacists' learning about PC. It was composed of 3 pharmacists and the Coordinator, PC. Once the Coordinator, PC position ended in June 1994, this responsibility was assumed by the Clinical Manager responsible for PC. The committee now meets on an "as required" rather than a regular basis. The objectives of the committee follow.

1. Review and recommend revisions to departmental PC practice and administrative issues related to PC.
2. Review and recommend revision to the PMDRP to suit the practice of the pharmacists at TEGH.
3. Develop and initiate a clinical profile (an abbreviated PMDRP) suitable for the documentation of the provision of PC; develop guidelines for the use of this profile.
4. Assess and make recommendations to meet the educational needs of the pharmacists with respect to PC.
5. Develop and recommend methods of communication between pharmacists to ensure continuity of PC upon transfer of patients within the hospital.

These methods included developing guidelines for documenting medication histories, patient education activities and pharmacy consults in the patient's health care record.

6. Investigate and develop methods for improving continuity of PC as they arise.

Pocket Cards

The PC Committee developed two pocket cards which include a schematic of the TTP and components of the PMDRP. More specifically, the pocket cards list the elements of a patient interview, a chart review and DRP identification, as well as the flowchart of the TTP. These were developed to act as prompts in the use of the revised clinical profile/abbreviated PMDRP so that the short form would not be used solely as a place to record data.

MODIFICATIONS TO EXISTING EDUCATION

Clinical Presentations

Clinical Presentations had been provided by pharmacists at TEGH on a rotating basis for several years as a means of keeping current as well as improving presentation skills. Originally, these were bi-weekly education sessions which were comprised of case presentations in combination with a pathophysiology and therapeutics discussion. In 1992, the format of the case presentations was modified to focus on identifying DRPs and formulating a pharmacy care plan for at least one DRP. Therapeutics issues pertinent to the specific case were discussed as they arose in identifying DRPs and selecting a therapeutic plan. This change in format resulted in presentations that focussed more on the patient and the application of the information. As well, there was much more discussion about the pharmacy care plan following the formal part of the presentation than previously occurred.

In an effort to make more time available for pharmacists to provide PC, the frequency of these presentations has been reduced to once per month.

Clinical Sharing

Clinical Sharing had also been held for several years - every 2 weeks. In contrast to the formality of the Clinical Presentations, Clinical Sharing was an environment where pharmacists informally shared aspects of cases of interest or sought guidance from colleagues. A temporary education element was provided during these Clinical Sharing sessions between January 1993 and June 1994. Specifically, the Clinical Managers and Coordinator, PC facilitated 10-minute discussions with the objective being that the pharmacists would learn how to provide all components of the PC process to their patients.[3,4] During these, the presenter would share pertinent aspects of a case and focus on how to apply a component of the PC process to the case. For example, the facilitator may have presented a patient's DRP and the

attendees would collectively develop desired patient outcomes or develop a therapeutic plan. A summary of the discussion was published in the departmental newsletter for the benefit of those not in attendance. Many pharmacists indicated that they gained from this opportunity to practice applying small aspects of the PC process at a time.

From January 1994 to June 1994, an attempt was made to gradually apply all steps of the PC process to a single case. This was found to be less successful than using different cases each week as it required a conscious effort by the pharmacists to come prepared for the discussion.

WHAT WE LEARNED

Much has been learned as the pharmacists have gradually but continually moved towards providing pharmaceutical care to patients in lieu of clinical services. No formal assessments were done along the way to determine whether any one facet of the departmental educational program was more successful than any other in assisting pharmacists in realizing the goal of being able to provide all steps of the PC-process to their patients. Based on subjective verbal feedback received at the time, it is the feeling of the authors that all components of the education program in some way supported the learning by the pharmacists. In keeping with adult learning principles[6] it is likely that each pharmacist gained benefit from some facet more than others but that there would not be agreement by the pharmacists as to the one most valuable component. It was vital to include a variety of concurrent PC-related learning activities to assure that the large majority of the pharmacists' learning styles and needs and skill levels would be accommodated.

In general, it could be said that the PC education program initially consisted of formal educational sessions regarding what PC is and one approach to providing it. Based on verbal feedback from the pharmacists, by far, the most important learning by the pharmacists did not occur during these educational sessions but rather on their own when they were trying to apply the concepts to their patient care. This "hands-on" learning was then supported by the clinical sharing sessions and the availability of coaching. The value of this support and encouragement, whether provided by a peer, coordinator, or manager cannot be understated. It is vital to the success of learning how to provide PC and how to incorporate it into one's practice.

In 1992, it seemed that the only option was to use the University of Toronto approach. It had already been developed through the collective efforts of many leading practitioners in the province. Also, many of the pharmacists needed to learn these processes as they were to act as preceptors for fourth year undergraduate students during their clinical clerkships. However, much has been

learned about pharmaceutical care over the last 5 or 6 years. A more participative approach would be to involve the pharmacists in the development of the general processes they would use to identify DRP and develop pharmacy care plans. This would accommodate for pharmacists' different learning, problem solving, and practice styles.

Another significant modification that would be valuable is to provide much more opportunity to learn about developing effective relationships with patients. This should include learning what constitutes an effective relationship (a covenantal one according to Hepler and Strand),[1] how to develop such a relationship using effective communication skills, and how to maintain such a relationship. The pharmacists at TEGH repeatedly discovered that the development of an effective relationship is fundamental to the provision of PC. This has led to some pharmacists modifying their routines; for example, some speak with their patients prior to reviewing their health care record to assess their drug-related concerns.

Experience in learning to provide and implement PC at TEGH has shown that the right balance of individual autonomy and learning, small group learning and sharing, and managerial leadership and support is required.

Operational issues must be addressed concurrently with educational efforts if what is learned is also to be applied. The learning must be ongoing and the process must be re-evaluated and modified continuously to reflect what has already been learned.

Despite the time expenditure involved, our experience has helped us to realize that if pharmacists are going to be able to incorporate PC into their practice, they need support and guidance to learn to provide it.

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Appendix A. Format and Learning Objectives of Workshops

Session	Type of case used	Learning Objectives "Upon completion of this workshop, the participants should be able to..."
1	fictitious - standuphairditis	• *explain the need for a systematic process to identify DRP*
2	CHF	• *explain one specific process to identify a single DRP (TTP[3])*
3	hypertension	• *use the TTP to identify a single DRP*
4	hypertension (same case as in Session 3)	• *explain how the TTP fits into the PMDRP[4]* *explain how the TTP does not facilitate provision of all steps of the PC process*
5	hypertension (same as above)	• *explain the intent of various section and questions of the PMDRP*
6	none; informal sharing of cases	• *explain what is meant by a covenantal relationship* • *explain why completing a PMDRP does not mean that PC has been provided*