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Reducing risk



The pharmacist's role in risk reduction is a key part of patient safety. This includes reducing the well-documented risks of medication errors, interactions and adverse effects. Risk assessment and risk management form the cornerstone of several alerts from the National Patient Safety Agency, and many other safety strategies.

The current national focus is on venous thromboembolism (VTE) risk. Preventing VTE is the top clinical priority for improving quality and productivity in hospitals in 2010–11, NHS medical director Sir Bruce Keogh announced recently. New NICE guidance published this month states that, for the first time, all patients admitted to hospital in England and Wales should be assessed for their risk of developing VTE, and measures taken to prevent it. This is a key part of the national quality agenda, and Martin Stephens, national clinical director with responsibility for hospital pharmacy at the Department of Health, has urged clinical pharmacy teams to support the initiative (*BJ Clin Pharm* 2010;1:7).

An article in this month's *British Journal of Clinical Pharmacy* describes how pharmacists can help implement the new guidelines (see News Feature, p39). Crucially, VTE is not an issue that only concerns cardiology pharmacists — all clinical pharmacists have a part to play in reducing the incidence of VTE, be it assessing patients' risk on admission, prescribing and advising on prophylaxis, writing trust protocols, or simply maintaining vigilance on the wards.

Still on the theme of risk reduction, new standards for pharmacy verification of chemotherapy prescriptions were published by the British Oncology Pharmacy Association this month (see Clinical Update, p41). While application of these standards will no doubt be key in meeting the national drive to improve the safety of systemic anticancer therapy, it is another example of work that should not be limited to one speciality. While designed primarily for oncology and haematology pharmacists, many other pharmacists will be involved in checking prescriptions for anticancer medicines for other indications (e.g. methotrexate for rheumatoid arthritis), and many of the standards are good practice for checking prescriptions for other high risk drugs.

Also in this issue, a Profile article (p53) describes the work of Sandra Allan, a specialist cardiac pharmacist who trained as an independent prescriber, set up a pharmacist-led arrhythmia clinic, and now personally administers electrical cardioversion therapy. Mrs Allan is one of the few clinical pharmacists to take on this unique role, which may have been unimaginable for a pharmacist several years ago, just as independent prescribing once was. We hope it will provide some inspiration about where the role of a pharmacist could lead, with the appropriate training, support and ambition.

**Hannah Pike, MRPharmS
Editor**

Showcasing your work

The *British Journal of Clinical Pharmacy* is continuing its campaign to encourage readers to showcase the work and research carried out in pharmacy departments across the UK. This month we have introduced a 'Short Report' section (see p59), through which readers can communicate brief audit results, trends or ideas. If you have something you would like to share please contact the editor, Hannah Pike, on 0208 241 6592, e-mail hannah.pike@pharmacypublishing.co.uk. We are also calling for full research papers — please contact the editor to discuss requirements, or for details of our peer review process.