

A Model for Pharmacist-Nurse Collaboration in Nursing In-Service Education

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INTRODUCTION

Generally, nurses and pharmacists do not fully appreciate each other's professional role, responsibilities, expertise, and attendant stress. A number of authors have addressed communication problems and the resulting conflict between pharmacists and nurses (1-3). In contrast, several studies have reported the positive aspects of increased frequency and personalization of interchange between nurses and pharmacists and the increased satisfaction with pharmaceutical services by nurses attributed to improved communication between the two groups (4-6).

Pharmacists traditionally have provided in-service education for nurses in various settings. The in-service presentations are usually planned lectures about specific drugs. A different format for in-service education by pharmacists may provide greater opportunities for learning, as well as enhance interprofessional communications between pharmacy and nursing. This paper describes a model for pharmacist-nurse collaboration for in-service education of nurses

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structured as a clinical conference coordinated by a pharmacist and a nurse.

REVIEW OF THE LITERATURE

Pharmacist-Nurse Communication

In Barker and colleagues' analysis of an existing hospital medication system, the number one problem identified by pharmacists was that of communication with nurses (1). Gourley and colleagues evaluated ASHP membership predictions of institutional pharmacy in the year 2000 (2). One key prediction was that the "turf conflict with the nurse will increase" (2). However, clinical pharmacists (a subgroup in the study) were least likely to foresee an increase in pharmacist-nurse conflict. The conclusion was that pharmacists who were routinely isolated from nurses were the least likely to predict an increase in conflict.

A number of studies have evaluated the change in attitude by the pharmacist and/or the nurse toward pharmaceutical services before and after decentralization (3-6). Nurses' attitudes toward pharmaceutical services improved after decentralization as a result of their increased contact with pharmacists. Sateren and Streit found that following decentralization, both pharmacists and nurses thought that communication between the two groups had improved in quantity and quality (4). Nurses also reported an increased satisfaction with the in-service education provided by pharmacists (5). In fact, their rating of pharmacists' in-service education programs increased more than the ratings for any of the other 14 areas assessed in this study.

Common to all the studies cited is the finding that increased contact between pharmacists and nurses led to improved communication. Although decentralization has been shown to improve communication, this is not a feasible option for all institutions. Alternatively, an increase in collaboration between pharmacist and nurse could also lead to improved communication. The nursing profession has participated in interdisciplinary education projects with other health care professionals with this aim in mind.

Collaboration in Nursing

The nursing literature is filled with studies of collaborative educational efforts aimed at promoting increased understanding of the roles of other professionals and improving the quality of patient care (7-10). A common theme in these articles is the value of exposing students, as well as practitioners, to colleagues from other disciplines. The underlying assumption is that professionals who understand their own role as it relates to others will be better prepared to work with members of other disciplines. Professional collaboration has become increasingly important. The proportion of patients requiring acute care has increased. There has also been a shift to a holistic approach to patient care attuned to more fully understanding the disease state (11).

Pharmacist-Nurse Collaborations

Little has been written about pharmacist-nurse collaboration in educational programs. McGinty, Chase, and Mercer described a discharge medication counseling program for cardiac patients coordinated by both nursing and pharmacy staff (12). The pharmacist's role was primarily as a content consultant in developing medication teaching cards for the patients. Prior to implementing the program, the clinical nurse specialist and the pharmacist jointly presented an in-service to prepare staff.

Nurses' contact with pharmacists is often indirect—via the telephone—and consists of requests for information about specific drugs or questions regarding the whereabouts of patients' medications. The impersonal contact makes it more difficult for nurses and pharmacists to fully appreciate each other's knowledge and expertise. This lack of understanding can lead to communication problems between nurses and pharmacists that adversely affect patient care (5).

Pharmacist's Role in Clinical Teaching

According to Wadd and Blissenbach, "providing drug information for physicians, nurses, and patients" is one of the major responsibilities of the pharmacist in a decentralized setting (3). Phar-

macists have also traditionally presented lectures about a specific drug or class of drugs during in-service programs to nurses (and others). This approach has apparent limitations. Lectures are generally structured and do not have the flexibility of a less formal approach to in-service education. In contrast, an informal format would allow for discussion of any topic of current interest or acute importance to nurses. Traditional in-services would, therefore, be reinforced by the clinical conference approach presented in this paper.

THE MODEL

The goals of the collaborative model presented here are twofold: to increase pharmacists' and nurses' understanding of each other's role, background, concerns, and stress and to improve the quality of patient care by increasing and reinforcing nurses' awareness of medication uses and effects.

In our model, the program leaders were a clinical pharmacist and a nursing staff development instructor. The in-service clinical conference in our model was unit based and scheduled for a particular day and time at the convenience of unit staff. A specific topic was not identified beforehand.

On the day of the clinical conference, the pharmacist and nurse cofacilitators proceeded to the unit 30-60 minutes prior to the conference. The coleaders met informally with available staff nurses, and through these brief discussions with individual nurses, the coleaders collected data about the staff members' current concerns regarding their patients or medications. Patient charts and medication administration records were reviewed. During the individual conferences, staff nurses frequently asked the pharmacist and nurse leaders specific questions. These were always answered briefly and, in many cases, were incorporated into the clinical conference if deemed of general interest. The major advantage of the individual conferences, however, was that the staff nurses had an opportunity to talk with the pharmacist and nurse experts on a one-to-one basis.

Because the focus of the clinical conference was usually pharmacological concepts related to patient care, the pharmacist generally initiated the discussion. The nurse leader's responsibility was to

ensure that the discussion incorporated nursing issues and was not merely a didactic presentation of drug information. Additionally, because of the previous individual conferences, time was not wasted on descriptions of patients or other background data during the group session. Thus, the conference was focused immediately. The emphasis of any particular conference varied depending upon the type of unit, the patient population, the staff experience level, and the immediate concerns peculiar to the unit. The group conference themes ranged from specific patient issues to general patient issues and from single-drug therapy to multidrug regimens. More detailed discussions evolved on topics such as the mechanism of action for individual drugs, potential drug-drug or drug-food interactions, and drug side effects. The nursing implications of patient monitoring (relevant nursing assessments and related laboratory values), scheduling medications, patient instruction, and appropriate nursing actions should adverse reactions occur were carefully integrated.

To more clearly illustrate the process of the clinical conference, several examples are provided. These are based on actual experiences by the authors. It must be noted that for each scenario described, a single drug or drug category was used; however, a conference usually proceeded on a more complex level.

Situation 1

A discussion of a patient with myasthenia gravis afforded an excellent forum to review the pathophysiology of a disease state. This included discussion of neurotransmitters, receptor sites, and the immune system in general. Also, the treatment may have included surgery, permitting an even more involved interchange than the usual discussion of therapeutics.

Situation 2

One extremely important session revolved around the use of aspirin. Although aspirin is a seemingly trivial drug and is often mistakenly considered innocuous, it became a widely discussed issue at the conference. Everyone was able to comment on personal experiences related to patient care. Indications, contraindications, side

effects, and interactions were shared. The co-leaders and participants ranked this session high in terms of practicality.

Some of the other successful conference topics included the pharmacokinetics of antianxiety drugs in the elderly, the ethics associated with the use of antipsychotic drugs, the multiple-drug regimens of the elderly, and the physiology and use of antacids versus H_2 -blockers.

Although the pharmacist usually initiated the discussion in the above cases, this would not preclude the nurse co-leader from starting the conference with a nurse-patient consideration rather than a drug-patient orientation. The nurse co-leader would review items such as potential drug interaction issues related to the scheduling of medications, the appropriate nursing actions for an observed adverse reaction, and the patient and/or family discharge counseling regarding medications. This last item may also include the "what to teach" as well as the "how to teach" issues.

Conferences generally lasted 30-60 minutes. Because there was no set agenda, staff nurses had the ability to individualize the conference to best meet their learning needs. The pharmacist and nurse co-leaders not only facilitated discussion but also functioned as consultants in their respective areas of expertise. In our experience, the scheduling of conferences must be done carefully, so that conferences do not become too routine or boring for the participants.

DISCUSSION

One advantage of this model is that the nursing staff development instructor or nurse clinical specialist can assist the pharmacist's entry into the clinical setting. Also, it is reasonable to expect that nurses might be more receptive to in-service education when it is presented by a peer with whom they are familiar.

The greater number of patients requiring acute care and the ever-increasing number of new drugs available make therapeutics-oriented in-service education for nurses essential, especially if nurses are going to maintain quality health care delivery. The model takes into account that the monitoring of patients for adverse effects is an extremely important component of nursing care. The ever-increasing complexity of many patient care situations requires input from

other health care professionals to effect a holistic approach to patient care.

Participation in the clinical conferences, both individual and group, allows nurses to meet pharmacists on a one-to-one basis. The literature has also suggested positive results in the enhancement of communication between nurses and pharmacists, especially when more in-person and frequent contact was possible (5, 6). Thus it is plausible to expect a similar result following the use of the educational model presented, particularly if these in-service/clinical conferences were scheduled on a regular basis.

Another facet of our work with this model was that nurses had a great interest in pharmacology and a great desire to update their knowledge in this area. The authors' experience in a large urban university setting has been that many registered nurses returning to school for a baccalaureate degree have opted to take a pharmacology course rather than the challenge examination. These same students, however, have routinely preferred the challenge examinations in other areas, such as nutrition, chemistry, microbiology, and anatomy and physiology.

The less formal, clinical conference approach to in-service education described here permitted more interchange among a greater number of participants than would be possible with a rigid didactic presentation. Nurses became more aware of the pharmacist's background, education, and depth of knowledge. This resulted in an appreciation of the pharmacist as a valuable resource. The pharmacist, in turn, gained a better understanding of the role of nurses and the numerous nursing concerns related to patient care.

In this model, the pharmacist and the nurse were facilitators as well as consultants during each clinical conference. As such, the preparation time necessary for a more formal in-service presentation, or structured lecture, was drastically reduced. In this era of personnel shortages and cost containment, time becomes an important consideration.

The proposed model is consistent with accepted principles of adult education (13, 14). The model also presupposes that nurses have certain knowledge about the patients, the disease states, and the medications in use; therefore, the role of the pharmacist-nurse leaders was to help nurses integrate this basic knowledge to achieve

a holistic approach to patient care. Participants were actively involved in the conference and had the opportunity to demonstrate what they already knew. Because the conference focused on current patients, conference-derived information could be applied immediately. The structure of the clinical conference was sufficiently flexible to allow nurse participants some input into the direction of the conference discussion. Furthermore, it was vital that the overall conference environment be informal and friendly.

Current trends seem to show some progress in cross-educational endeavors. Pharmacy in-service is now including more nurses. The nurse participants provide the pharmacist with an insight into patient concerns. Some schools of pharmacy have included nurses as faculty and vice versa.

CONCLUSIONS

Communication problems between pharmacists and nurses have been identified repeatedly in the literature as a major concern. The authors believe that the collaborative model of nursing in-service education presented here will foster improved communication between the two groups, enhance mutual appreciation of the professions, and provide continuing education with the goal of maintaining excellence in the health care delivery system.

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