Extended independent nurse prescribing in palliative care

IN 1992, the Medicinal Products: Prescription by Nurses Act was passed, permitting nurses with a district nurse and health visitor qualification to prescribe from a limited formulary of products. The initiative, known as independent nurse prescribing, is now well established, with more than 22,000 community nurses trained as prescribers (DoH, 2002). The aim of introducing extended (independent) nurse prescribing was to maximise benefit to patients by establishing quicker and more efficient access to medicines and to make the best use of nurses’ skills.

With the exception of controlled drugs, extended formulary nurse prescribers are authorised to prescribe all pharmacy and general sales list medicines currently prescribable by general practitioners and specific prescription-only medicines (POMs) to manage a range of specified medical conditions from the following four categories:

- Minor injuries such as burns, cuts, sprains;
- Minor ailments such as hay fever and acne;
- Health promotion and maintenance such as providing vitamins for women planning pregnancy;
- Palliative care.

Prescribing and palliative care

In some trusts, palliative care nurses working at consultant, specialist and practitioner level have completed training to prescribe from the extended formulary. Traditionally, palliative care nurses have advised doctors on medication regimes. Extending prescribing practice offers specialist palliative care nurses the opportunity to formalise this practice and to work more autonomously. This is a different role from those nurses who diagnose and prescribe drugs for the other three categories of conditions permitting nurses to prescribe from the Nurse Prescribers’ Extended Formulary.

Symptom control is one of the essential components of palliative care and is vital for achieving optimum physical and psychological well-being of patients (WHO, 1990). Being able to prescribe immediately and appropriately in response to patients’ needs promotes a seamless service that will reduce distress for patients and carers. This change in practice means that palliative care nurses will be assessing, diagnosing and prescribing in isolation, often dealing with multiple medication regimes (polypharmacy). Prescribing decisions will often involve considering other ongoing treatments such as chemotherapy, although the work of palliative care nurses covers a range of life-threatening illnesses, not only cancer.

Extended prescribing in palliative care involves making complex decisions in situations where often there are no clear rights or wrongs. Specialist nurses should therefore consider carefully whether they are both willing and capable of undertaking these responsibilities. The Department of Health (DoH, 2002) has clearly stated that the choice of undertaking extended nurse prescribing rests with the individual nurse.

Which drugs?

The Nurse Prescribers’ Extended Formulary has been substantially reduced from that originally proposed, and the range of POMs is limited (see Table 1). For example, many drugs routinely prescribed in palliative care, such as corticosteroids, some anti-emetics and adjuvant analgesics, are not on the list. The prescribing of controlled drugs is a more complex issue as their use is subject to controls under the misuse of drugs legislation (DoH, 2002). Currently they can be prescribed only by a doctor. However, doctors often prescribe controlled drugs on the guidance of specialist palliative care nurses.

The disadvantage of having a limited formulary is that it may result in confusion and, in some cases, duplication of prescriptions. If a patient requires controlled drugs plus another drug, it would be more convenient for the patient to be issued with only one prescription. This situation will continue, however, until the scope of extended prescribing includes most, if not all, of the drugs in the British National Formulary (RCN, 2001). In the interim, extended nurse prescribers must ensure that their practice follows local and national guidelines.

Using drugs beyond product licence

A further limitation of nurse prescribing is not being able to prescribe drugs beyond their product licence. In palliative care, 25% of all prescriptions are for licensed drugs that are used for unlicensed indications or given by an unlicensed route (Atkinson and Kirkham, 1999). Doctors are permitted to prescribe outside the remit of the licence, but nurses are denied this clinical freedom. The Department of Health (2002) states that: ‘Nurse prescribers should not prescribe medicines for uses outside of their licensed indications (off-licence),’ a state-
Transferring theory into practice.

At present there is a paucity of guidance regarding assessing competence in prescribing in palliative care. A nurse assessment includes a face-to-face consultation with the patient; a review of the patient’s medical and medication history, together with an analysis of the patient’s notes, recent blood tests and investigations. It does not routinely include making a clinical examination. However, when a nurse’s assessment results in an unclear diagnosis that involves a prescribing decision, clinical examination of the patient by a medical practitioner is requested.

Some extended formulary nurse prescribers have further developed their assessment skills to include clinical examination through working closely with their medical supervisor; for example, auscultation of bowel sounds and percussion of the upper abdomen to assess and diagnose bowel obstruction. Although we support the advancement of nursing skills within autonomous practice we question whether 12 days ‘learning in practice’ are sufficient to provide practitioners with the skills to perform clinical examinations.

Once a nurse has passed the course, the university notifies both the nurse’s employer and the Nursing and Midwifery Council (NMC) so that the nurse’s competence to practise can be annotated on the NMC’s professional register. A nurse cannot legally prescribe until this annotation has been made. Confirmation of registration, which takes approximately 10 days, is the responsibility of the nurse, who subsequently informs his/her employer.

Employers of nurse prescribers in primary care, but not secondary care, must inform and register the nurse prescriber’s details with the Prescription Pricing Authority (PPA). The employer also has to obtain prescription pads for hospital use that provide both the nurse’s and the hospital’s details. It is also the responsibility of the nurse, who subsequently informs his/her employer.

Educational preparation

Nurses must undergo a programme of preparation in a validated university to qualify as an extended formulary nurse prescriber. The programme covers four areas: principles of prescribing, practice; accountability; responsibility. Twenty-five days are spent in the classroom and 12 days are spent ‘learning in practice’. The latter includes having regular contact with a designated supervising medical practitioner whose brief is to provide the student with supervision, support and opportunities to develop competence in practice. Assessment of the nurse’s competence to prescribe is the responsibility of the medical supervisor.

Finding suitable medical practitioners to agree to participate in this programme is going to be a challenge in palliative care as there are relatively few practitioners available to offer the appropriate level of support for nurses practising at specialist and advanced level. GPs and hospital doctors are currently being approached to provide this supervision and although they are able to provide support in terms of generic prescribing, they may lack the level of expertise in palliative care to be able to develop further the specialist nurse’s skills.

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as improving professionals’ use of their time.

Because safe practice is regarded as paramount, it is agreed locally that the nurse prescriber discontinues medications not currently in either of the nurses’ formularies, such as haloperidol, when it is no longer indicated on the revised drug régime.

The document Maintaining Competency in Prescribing (National Prescribing Centre, 2001) will assist us and our managers to support and further develop prescribing competences.

Legal liability and prescribing practice
All prescribing nurses are required to prescribe within their professional code of conduct, individual professional competence, and in accordance with the nurses’ formularies. Nurses must ensure that their contract of employment is amended to include extended prescribing. This will ensure that the employer has vicarious liability for the nurses’ actions when undertaking prescribing as part of their nursing duties. Under United Kingdom law, the legislative requirements relating to the prescribing, supply and administration of medicines are set out in the Medicines Act 1968 and in subsequent legislation made under the Prescription Only Medicines (Human Use) Order 1997. (SI No.1830) (DoH, 1997).

Any breach of the Medicines Act is an offence liable to criminal prosecution. This is in addition to any civil liability which may follow as the result of private litigation brought against the prescriber following wrongful supply which may have resulted in death or injury to a patient (DoH, 1998).

Extended prescribers must have access to legal advice and support both from their professional organisation, the NMC and their employer.

The importance of communication
The introduction of extended nurse prescribing, and the shift towards specialist nurses taking more decision-making responsibility, may result in less doctor/patient contact. It is essential, therefore, that effective communication networks are in place to allow collaboration between doctors and prescribers so as to avoid vital omissions or duplications in prescribing. Thus, current communication and documentation channels must be reviewed, amended and further developed.

Extended nurse prescribing offers a particular challenge to nurses working in the community because of the wide geographical areas covered by both palliative care nurses and nurses in primary health care teams, making communication difficult. For instance, access to patients’ records is often limited by distance, time and surgery opening hours. Thus nurse prescribers may find that patients’ records, and their comprehensive and up-to-date medical and drug histories, are not readily accessible and that the only source of information is from the patient and/or carers. Telephone contact relies on surgery opening hours and the availability of an informed practitioner to whom a relevant case may be disclosed. A lack of information will not only influence the prescribing decision, but may also affect patient/carer concordance and informed consent. The nurse prescriber is, however, fully accountable for his or her practice (NMC, 2002) and should prescribe only in situations where there is adequate and sufficient information.

With the development of electronic prescribing and eventually the use of electronic records, some of these problems will be overcome. However, until such time, it is imperative that nurses invest time and effort in obtaining full access to patients’ records before they issue a prescription.

To ensure that prescribing practice is safe and effective, with clear benefits for the patient, robust mechanisms for evaluating this change in practice are essential. On a local level, collaboration between academic institutions and trusts in the promotion of valid and reliable research programmes examining the effectiveness of extended nurse prescribing may be the way forward.

Conclusion
If an holistic, seamless palliative care service is to be offered to patients, and if the government’s objectives for the implementation of extended prescribing are to be achieved, further developments will need to be put in place:

■ Nurses must be licensed to prescribe across the entire British National Formulary, including unlicensed medicines and opioids;

■ Continuing professional development must be mandatory;

■ Effective communication networks must be set up;

■ Ongoing clinical supervision must be available in order to promote safe practice;

■ Commissioners of primary care and acute trusts must be committed to supporting extended nurse prescribing in palliative care;

■ Local palliative care formularies must be further developed;

■ There must be collaboration between pharmacists across all care settings;

■ Extended nurse prescribers must be recognised financially.

The challenge for palliative care nurse prescribers is to examine the changing environment in which they work and to identify the demands and opportunities to facilitate a workable system. Patient safety is paramount and relies heavily on well trained, confident, experienced nurses with excellent communication skills and the ability to assess and prescribe appropriately. Palliative care nurses are well placed to deliver this standard of care.

Further extension of the Nurse Prescribers’ Extended Formulary will enable nurses actively to meet the challenge of the NHS modernisation agenda. However, it is imperative that palliative care specialists make their views known, share experiences and lobby for an improved, workable formulary that will be able to offer patients quality of care.