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Title : Non-Medical Prescribing in Palliative Care: A Regional Survey.

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Background

The UK is considered to be the world leader in Non Medical Prescribing (NMP) practice and although growth is evident elsewhere (Australia, Canada, New Zealand and the United States) no other country has the same extended non-medical prescribing rights as the UK [1]. There are now 54,000 nurse and midwife prescribers across the UK prescribing over 12.8 million items per year. [2] Arguably this growth has outpaced research to evaluate the clinical and economic value of NMP.

The legislative changes have taken place over a 15 year period, reflecting a consistent cautious evolution of the role, by 2006 almost all the British National Formulary was opened up to nurse prescribers with the restriction of some controlled drugs. In April 2012 further legislation [3] enabled NMPs to prescribe controlled drugs within their competence. Essentially nurses with a NMP qualification now have the same prescribing capabilities as doctors.

Guidance on implementing NMP [4] predicted benefits would be; improved patient care without compromising safety, improved access to medicines, better use of healthcare professionals' skills and more flexible team working across the NHS. Whilst some of these benefits have been substantiated through research, there is still relatively little empirical evidence to support clinical and economic outcomes. [5] This is particularly true of evaluations of NMP in specialist palliative care settings [6], we identified only one previous national survey of NMP in palliative care [7] conducted in 2005, and limited to community palliative care nurses.

NMP in a palliative care context may be one mechanism through which people can be supported to remain at home with well controlled symptoms at the end of life. For example, patients with cancer typically spend 65-80% of their last 6 months of life at home and adequate pain control is often hindered by poor access to effective timely analgesia. These patients often have multiple, rapidly changing symptoms requiring highly specialist management.[8] The UK's Nursing and Midwifery Council accredited independent prescribing course consists of 26 days teaching and learning and a minimum of 12 days in practice under the supervision of a designated medical practitioner.

Aim

To explore the barriers to becoming a qualified NMP, investigate NMPs' experiences of the transition from qualifying as a prescriber to prescribing in a palliative care context, determine the range of medicines nurses prescribe for cancer pain and establish the impact on practice of the 2012 NMP legal changes[3].

Design

An online survey was designed using SurveyMonkey software and consisting of 9 sections; general information, experiences before, during and after the prescribing course, prescribing practice, clinical governance and risk management, prescribing for pain in palliative care, opinions about independent prescribing and views on support and continuing professional development. The pilot testing indicated the survey would take less than 20 minutes to complete.

Participants

The participants were nurse members of a regional cancer network palliative care group (n=61). The maximum number of questions was 55 (for respondents who were currently prescribing) and the minimum number was 7 (respondents who were not qualified prescribers). The draft questionnaire was reviewed by a small group of specialist cancer nurses to enhance content and face validity. The link to the online survey was circulated by email during May and June 2013 and was followed up with a reminder email 2 weeks later. Ethics committee approval was obtained for this study (ref: HSLTLM/12/067). The survey responses were exported to SPSS for analysis and free text responses were analysed by theme and categorized.

Results

A 61% (n=37) response rate was obtained. The majority of respondents were clinical nurse specialists in palliative care (n=27; 75%). Other respondents were advanced nurse practitioners (n=3; 8%), or senior nurses with management or educational roles within palliative care settings (n=6; 17%). Most (n=26; 70%) worked full time and most respondents (n=31;84%) were aged between 41 and 55 years. Three (8%) were less than 40 years of age and three (8%)were 56 years of age or older.

Nurse prescribers

14 (38%) respondents were qualified independent prescribers and currently prescribing, three (5%) were currently training, three (8%) were recently qualified and waiting to start prescribing and 18 (49%) were not qualified as independent prescribers. Of the respondents who were qualified prescribers, six (33%) had qualified within the last 2 years, six (33%) qualified 3-4 years ago, and five (28%) 6-7 years ago. One respondent had been qualified for 9 years. 28 (78%) respondents reported a non-medical prescribing qualification is relevant to their current role.

Non prescribers

Of the non prescribers (n=18), two (13%) were already either enrolled on or planning to undertake the course in the near future, six (40%) reported they did not perceive a need for the qualification and four (27%) reported being constrained by lack of time. A small number of respondents (n=3; 20%) explained they would be motivated to become a prescriber by a financial incentive such as a pay rise or promotion or if the prescribing course was part of a recognised broader academic qualification.

Decision to undertake the prescribing course

12 (63%) reported it was entirely their own decision to undertake the course and five had made the decision jointly with their employer. No respondents reported they became a prescriber solely at their employer's request. All respondents were motivated to undertake the course by the belief it would increase the quality of existing patient care and make patient access to medicines quicker and more efficient.

Transition to prescribing

Only three (31%) of the 14 respondents currently prescribing started prescribing within 2 months of qualifying and 8 (57%) were delayed by between two and four months, with the longest reported delay of over six months in one case. On completion of the course, only one respondent said they felt completely prepared to prescribe. Concerns about prescribing related to a lack of confidence (n=5;36%), a fear of making a prescribing error (n=2;14%), lack of GP support (n=2;14%) and lack of peer or management support (n=2;14%).

Prescribing practice

In terms of prescribing specific to cancer pain, all respondents reported they were prepared to initiate an oral opioid, a subcutaneous infusion and adjuvant pain treatment such as gabapentin or carbamazepine. Most (n=12; 86%) reported that the change in controlled drugs legislation had positively influenced their practice. Most prescribing took place in a patient's home (n=9; 64%) or inpatient setting (n=6; 43%). Less prescribing was undertaken in outpatient clinics (n=3;21%) or hospice settings (n=1;7%) .

Insert table on analgesics and associated medicines prescribed for cancer pain. (Table 1)

Discussion

This survey was distributed 12 months after the legislation permitting the prescribing of controlled drugs [3]. It differs from previous NMP surveys in that it focuses on nurses working in palliative care and incorporates the views of both non prescribers and prescribers. In terms of barriers to becoming a prescriber several non-prescribers cited 'lack of time'. Support through adequate study leave and covering current work load may help overcome this. Whilst the extensive range of drugs NMPs prescribe for cancer pain is apparent in Table 1 it perhaps belies the fact that only a minority of qualified prescribers felt completely prepared to prescribe on completing the course. This is in line with previous findings [1 8 9] that experience helps to maximise the prescriber's role and reinforces the requirement for ongoing support and mentorship. Concern has been expressed previously [10] about the economic implications of training prescribers who do not go on to prescribe; in 2007 over 50% of community palliative care qualified NMPs were not actually prescribing [7]. In contrast no qualified prescribers in our survey fell into the 'never prescribed' or 'stopped prescribing' categories which suggests support and mentorship may be particularly strong within our surveyed population. Of concern however were reported delays between qualifying as a prescriber and actually prescribing. This delay should be addressed to maximise value and ensure skills learned are translated into practice within reasonable time frames. The concerns expressed by NMPs in previous surveys regarding prescribing opioids[11 12] were not represented here. This suggests the legislative changes were well timed to coincide with a sense of readiness among nurses to take on this extension to their role. This study has limitations, it is a small scale survey of the membership of one regional palliative care nurses group within the UK and our findings therefore may not be representative of all nurse prescribers working in palliative care. We were unable to obtain information on non-responders so differences between responders and non- responders could not be explored.

Conclusion

Whilst this survey found NMPs have embraced the 2012 legislative changes to prescribing and clearly prescribe a wide range of drugs for cancer pain previously unavailable to them, we also identified scope to improve the transition from qualified to active NMP by reducing the time interval between the two. Nurses who may be considering training to be a NMP may be encouraged by the provision of adequate study leave and support to cover clinical work. Further research should explore the patients' perspective of NMP and economic implications.

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views expressed in this report are those of the authors and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health.

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Table 1 Analgesics prescribed for cancer pain n=14

–	Frequency				
	at least once a week –	at least once a month –	at least once every 3 months –	less than once every 3 months –	Total –
Laxatives	57.14% 8	42.86% 6	0% 0	0% 0	14
Anti-emetics	64.29% 9	28.57% 4	7.14% 1	0% 0	14
Paracetamol	57.14% 8	28.57% 4	14.29% 2	0% 0	14
Ibuprofen (200mg or 400mg)	0% 0	84.62% 11	0% 0	15.38% 2	13
Topical Capsaicin	0% 0	0% 0	11.11% 1	88.89% 8	9
Codeine	0% 0	41.67% 5	16.67% 2	41.67% 5	12
Codeine and paracetamol	15.38% 2	38.46% 5	23.08% 3	23.08% 3	13
Dihydrocodeine	0% 0	14.29% 1	0% 0	85.71% 6	7
Dihydrocodeine and paracetamol	0% 0	0% 0	16.67% 1	83.33% 5	6
Codeine and ibuprofen	0% 0	0% 0	33.33% 2	66.67% 4	6
Buprenorphine	0% 0	41.67% 5	16.67% 2	41.67% 5	12
Tramadol	0% 0	25% 2	12.50% 1	62.50% 5	8
Pethidine	0% 0	0% 0	0% 0	100% 5	5
Meptazinol	16.67% 1	0% 0	0% 0	83.33% 5	6
Tapentadol	16.67% 1	16.67% 1	0% 0	66.67% 4	6
Diamorphine	27.27% 3	45.45% 5	18.18% 2	9.09% 1	11
Morphine	53.85% 7	23.08% 3	15.38% 2	7.69% 1	13
Oxycodone	41.67% 5	41.67% 5	16.67% 2	0% 0	12
Fentanyl	0% 0	42.86% 6	42.86% 6	14.29% 2	14
Hydromorphone	20% 1	0% 0	0% 0	80% 4	5
Buprenorphine	11.11% 1	33.33% 3	33.33% 3	22.22% 2	9
Pentazocine	0% 0	0% 0	0% 0	100% 5	5
Dipipanone (with cyclizine)	0% 0	0% 0	20% 1	80% 4	5
Papaveretum	0% 0	0% 0	0% 0	100% 5	5
NSAID	30.77% 4	46.15% 6	23.08% 3	0% 0	13
Amitriptyline, Nortriptyline, Pregabalin, Gabapentin, Duloxetine, Carbamazipine (200mg)	16.67% 2	50% 6	25% 3	8.33%	