Community Palliative Care Clinical Nurse Specialists as Independent Prescribers: Part 1

An exploration of Community Palliative Care Clinical Nurse Specialists experiences of working as Independent Prescribers PART 1

Kathy Latham. Teacher Practitioner, St Michael's Hospice

Brian Nyatanga. Senior lecturer, academic Lead Centre for Palliative Care, University of Worcester

Correspondence

Brian Nyatanga b.nyatanga@worc.ac.uk

Abstract

The Department of Health has recently reiterated its commitment to the improvement in the quality of end of life care and emphasized the importance of all patients having rapid access to medication. The aim of this study was to explore the lived experiences of clinical nurse specialists who are able to prescribe independently in their role in providing support for patients with palliative care needs within the community setting. Interpretive phenomenology was employed in order to understand and interpret the experiences of six nurse independent prescribers employed as community palliative care clinical nurse specialists. This purposive sampling was preferred with semi-structured interviews as the most appropriate data collection technique. Participants interviewed reported that being able to prescribe enabled them to provide seamless, holistic care which facilitated faster access to medicines for their patients. This was particularly apparent at weekends when the patient's usual general practitioner (GP) was unavailable. Several benefits of nurse independent prescribing were also highlighted. However, the main barrier identified by most participants was the difficulty in accessing the patients' records. The overwhelming conclusion was that independent prescribing by community nurse specialists is beneficial for patients in the palliative care phase of their life and those deemed important to them as they are being cared for at home. Such benefits can also impact on other aspects of the patient's life including prompt availability of medicines, effective symptom control and consequently, an improved or enhanced quality of life for the patients and job satisfaction for the prescribing specialist nurses.

Key Words:

Palliative care; Non-medical prescribing; Nurse independent prescribing; Nurse prescribing; end of life care, Community

Ethical approval

Ethics approval was obtained from the University of Worcester's Institute of Health and Society Ethics Committee. Local Trust approval from the Audit, Research & Clinical Effectiveness group of Health and Care NHS Trust was obtained prior to conducting this study.

Introduction

The End of Life Care strategy (DH, 2008) emphasizes the importance of patients being able to die in their preferred place of care and having the care they need when they need it. Patients with palliative care needs may have rapidly changing and complex symptoms which require careful monitoring and review of medication, especially towards the end of their life. The Department of Health has recently reiterated its commitment to the improvement in the quality of end of life care (DH, 2014) and emphasizes the importance of patients having rapid access to medication (NICE 2015).

The role of the community palliative care clinical nurse specialist (CPC CNS) is diverse, providing symptom management, psychological, social and spiritual support to patients and their families within the community setting. They are employed as autonomous practitioners working across and liaising with several different health care settings.

Typically, each CPCCNS will have a case load of patients. A core aspect of the role is to get to know the patient and family and establish a relationship over a period of time.

The value of the nurse independent prescriber in the provision of palliative care:

Webb and Gibson, (2011) clearly show that palliative care CNSs who are also non-medical (independent) prescribers are instrumental in enabling patients to die at home. Report from Dhalivaal (2011) confirms that patients appreciate CNSs' prescribing role and view it as helping to improve the quality of their care.

Many commentators including Downer and Shepherd (2010) and Young (2009) conclude that independent prescribing within the community facilitates seamless and holistic care. This in turn would arguably lead to comfort and even dignity to patients.

Despite these perceived benefits, Cole and Gillet (2015) and Ryan-Woolley et al (2007) claim that some nurses are not able to prescribe for different reasons including barriers they encounter in the community. Although prescribing has been well evaluated in other care settings (Latter et al, 2011) there are very few studies that focus on the role of nurses and their experience of working as non-medical (independent) prescribers in the community specialising in palliative care. The education

and training to become a NMP is expensive, both in terms of money and time, not only to the nurse but also to the employing organisation, therefore, it is important these nurses are able to use these skills once qualified to do so. It is imperative that we understand the experiences of these independent prescribers in order to maximise their expertise for patient gain within the community.

Aim of study:

This study aim was to explore the lived experiences of clinical nurse specialists who work as independent prescribers with palliative care patients within the community setting.

Literature review:

A literature search was conducted in February 2015 using MEDLINE, CINAHL and the SUMMON search engines. The inclusion and exclusion criteria used for this study can be found in appendix 1. There appears to be very few studies since 2006 that considered the views of NIPs on their prescribing practice that are specific to community palliative care. Only one study by Ziegler (2015) was identified that specifically explored the experiences of NIPs in palliative care in relation to their prescribing practice. Ziegler reported mixed results including barriers to prescribing, lack of knowledge and inter-professional conflict. However, where support from management of medical colleagues was given nurse prescribers were reported to be more confident and improved patients' quality of life. Downer and Shepherd (2010); Courtenay et al (2012) and Stenner et al (2010) had earlier reported a lack of confidence and fear of prescribing errors among nurses. This paucity in existing evidence presents an opportunity and rationale for this current study. The issues that community palliative care CNSs encounter in their prescribing practice are unique to this cohort of nurses and may impact on their decisions to prescribe. It is still not clear how the nurses views on prescribing influence or impact their nursing practice. It was important for this study to ascertain these views in terms benefits and drawbacks with a view to establishing the nature of impact these might have on day to day nursing practice by this group of nurses. By extension, the impact would also be understood in terms symptom control and quality of life for patients with palliative care needs living within the community setting.

Research methodology

This study utilised qualitative research methodology and specifically Interpretive phenomenology in order to understand the different lived experiences by specialist nurses working and prescribing medicines in the community setting. Interpretive phenomenology (Heideggerian) principles allows researchers to understand lived experiences (Heidegger 1962) by ascertaining meaning through interpretation. The underlying premise for phenomenology in general is ontological which seeks to elicit the critical question: what is Being?. Being and being in the world are part of the ontological dimension of how we understand the phenomenon as it appears to our senses (ie, that which we are conscious of) (Heidegger 1962). For Heidegger, lived experience is inherently an interpretive process (Heidegger 1962) which leads to the meaning of the experience. In this study the Heideggerian approach was utilised to understand nurses' perception of their lived experiences of working as independent prescribers with dying patients being cared for in the community. The preference for Heideggerian phenomenology was based on its philosophical underpinnings that favour an ontological and not epistemological dimension of understanding the essences or lived experiences (Polit and Beck 2017). Unlike descriptive phenomenology, Interpretive phenomenology (IP) allows the researchers to interpret patients' narratives whilst using the researchers own subjective frame of reference (Parahoo 2014) in order to arrive at meaning. Allowing the researchers prior understandings is contrary to the idea of bracketing, which is suspension of researchers' prior understandings of the phenomenon (independent prescribing), in order to understand nurses prescribing experiences as they are. Heidegger viewed bracketing not only as impossible but as denying reality of being-in-the-world with all the experiences (Parahoo 2014; Polit and Beck 2017). Therefore, this study preferred an interpretive phenomenological methodology to enable interpretation of the nurses' experience of independent prescribing. van Manen (1990) has long claimed that we, as researchers use our self-knowledge, suppositions, biases of, in this study, palliative care and independent prescribing, the literature around it and other relevant sources to reflect on and understand the interview data in order to interpret what nurses are telling us. It is

important to stress that the researchers are making their interpretation of nurses' interpretation, hence dual or multiple interpretation occurs, which the IP also embraces Heidegger 1962). This methodology also allowed us to derive meaning from nurses' narratives of how they felt during and after prescribing independently. The methodology derives its strength from its ontological dimension that provides clear direction and principles necessary for conducting such research (Heidegger 1927).

Furthermore, phenomenology as a philosophy is underpinned in the belief that people attempt to interpret and derive meaning from their individual experiences (Bowling, 2014) and that each individual may derive a different meaning despite experiencing the same phenomena (Offredy and Vickers, 2010; Parahoo 2014) and in this study independent prescribing. As a method of enquiry, phenomenology aims to discover the lived experience of people, the essence or characteristics (Polit and Beck, 2014). Further, it is concerned with discovering how this experience and the understanding of it, relates to those of other people and the environment in which this experience takes place (Parahoo 2014). The purpose of the study was to try and understand the experiences of the participants and what meaning they attributed to them. A degree of and interpretation was therefore necessary to arrive at these meanings.

The use of phenomenology naturally utilises relatively small sample sizes, therefore there is no intention to generalise the findings from this study. However, it is critical to emphasise that the findings are likely to resonate or extemporize with others who receive qualification to prescribe independently. Denscombe (2014) is clear the strength of this methodology is that it allows for competing versions or alternative realities of what independent prescribing means for each specialist nurse to be exposed and understood.

The point to emerge is that there may not be one correct or right approach, but that, experiences may differ on cultural and social grounds and therefore different theories on the same experience may in fact be valid.

Recruitment of participants

A purposive sampling technique was used to recruit participants from the thirteen hospices across the West Midlands. Apart from the researchers living and working in the West Midlands, this area is seeing a lot of independent prescribers qualifying from local Universities training programme and start their prescribing here. However, multiple sites within the West Midlands were used to reduce the risk of geographical bias (Offredy and Vickers, 2010). These multiple sites ensured that nurses employed in both urban and rural areas were included in the study and thus highlighted any differences in practice that may be attributed to geographical context. A total of ten participants were recruited and four were not able to attend for interview on the day, (no reason given or expected), therefore six participants were deemed the sample and were interviewed individually. All ten had fulfilled the eligibility criteria (see Box 1 below).

Box 1: Eligibility criteria of participants

- Clinical nurse specialist
- Employed in specialist palliative care setting
- Partly or wholly community based working
- Qualified as Nurse independent prescriber
- Currently independently prescribing in their role

Data collection

Data were collected between July and September in 2015. An interview schedule was developed to guide the individual face-to-face semi-structured interviews that were conducted at a mutually agreed conducive location. This allowed the participants to freely express themselves but within a set framework of questions (Parahoo 2014). The length of interviews ranged between 35 to 75mins which was deemed appropriate to gain maximum concentration (Parahoo 2014) and explore all the issues.

Interviews were tape recorded, transcribed verbatim by the researcher and sent to each participant for validation. Responses from participants indicated that the interviews had been accurately transcribed. Data was analysed and themes identified using a constant comparison method (Thomas 2013). This technique, despite originating from Grounded theory research (Glaser and Strauss 1967), was adopted for this study as it shared and espoused similar underlying philosophy of understanding lived experiences (Parahoo 2014).

Data analysis

The constant comparative method (Thomas, 2013) was preferred for its simplicity in its extraction of themes and meanings being constructed by both the participants first and then the researcher. Data from each interview were constantly comparatively compared to confirm key themes. This involved reading through the interview transcriptions in full, identifying any possible themes, ideas and categories which were then highlighted and listed as temporary categories or 'constructs' (Thomas, 2013).

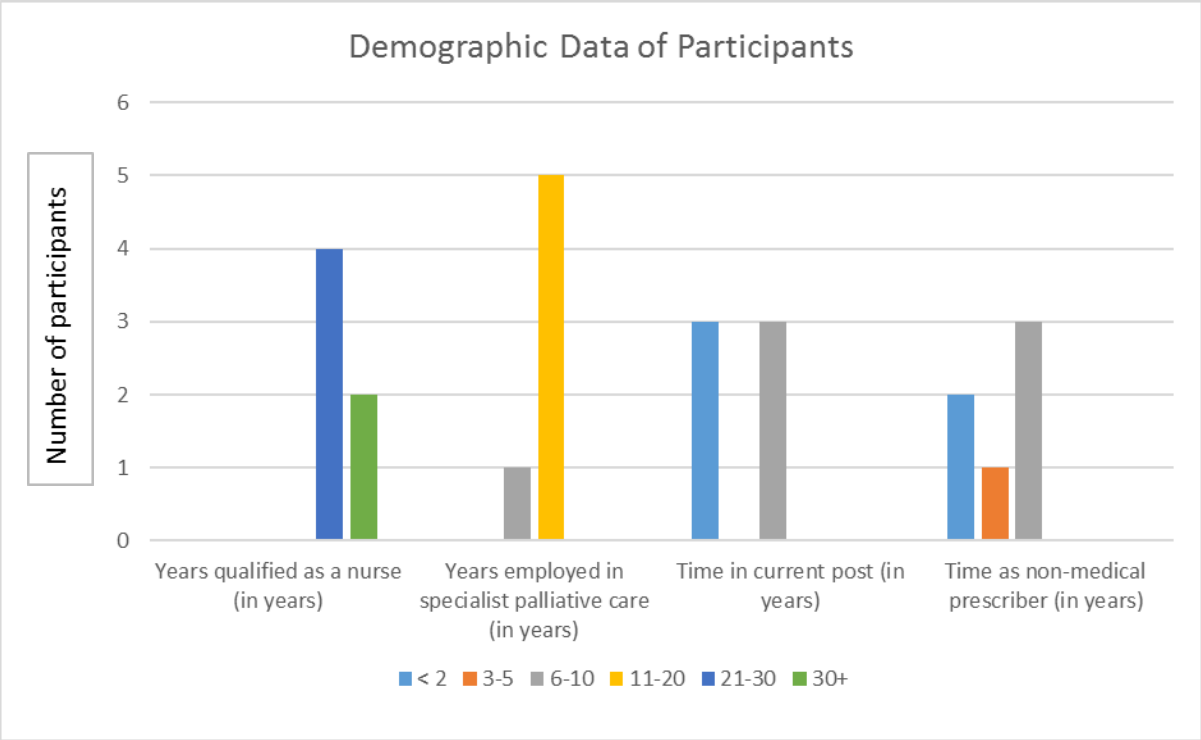
These categories were entered onto a grid with the location of each theme. Further reading of the transcriptions enabled natural variations and similarities between the data to be sought, which ensured that the categories discovered were as diverse as possible. This constant comparison between the transcriptions allowed 'second-order' constructs to be developed from which themes were identified (Thomas, 2013; Braun and Clarke 2012). Network analysis was then used to show how one theme related to another (Thomas 2013). In order to gain a better understanding of the data, the transcriptions were read and reread, both as a whole and in parts, thus making use of the hermeneutic cycle that is necessary for interpretative phenomenology (Gadamer, 1975; Polit and Beck, 2014), which gives confidence in some way that the researcher's understanding was closest to how the participant experienced the phenomena. Interpretations were made from the identified

themes in an attempt to derive meaning from them as described by participants and understood by the researcher.

Results

Demographic information relating to participants is shown in table 1 below.

Table 1: Demographic data of participants:



All participants had a minimum of six years of experience working in specialist palliative care, and one participant had twenty years of experience. One participant had been qualified as a nurse independent prescriber for less than two years with the remaining five being qualified for between three and ten years. Time in current post varied from between less than two years and twenty years.

Five broad main themes were identified and extracted from the transcribed interview data. The first two main themes also had sub-themes extracted which are all discussed below. Table 2 shows a summary of the main themes and sub-themes.

Table 2: summary of identified main themes and sub themes

Main themes	Sub-themes
Perceived benefits of nurse independent prescribing	• **Helping patients in times of 'crisis'** • **Being available when others aren't** • **Gaining satisfaction from being able to provide holistic care** • **Knowledge to prescribe the right medicines at the right time** • **Increased knowledge of pharmacology**
Perceived barriers to prescribing practice	• **Anxiety of writing prescriptions incorrectly** • **Inadequate knowledge** • **Negative or unfavourable attitudes of other health care professionals** • **Difficulties or challenges to accessing patients' notes**
Impact of prescribing on role	**No sub theme**
Reflections on NIP course	**No sub theme**
Views about recommending role to others	**No sub theme**

Discussion of main themes and sub-themes

NB: Conflict of interest: the authors have no conflict of interest with this study. No funding was received to conduct this study

References

Braun, V. & Clarke, V. (2012) Thematic analysis. In Cooper, H. (Ed.),
The Handbook of Research Methods in Psychology . Washington, DC: American Psychological Association.

Cole, T. & Gillett, K. (2015) Are nurse prescribers issuing prescriptions in palliative care? *Nurse Prescribing* 13 (2), 98-102

Denscombe, M. (2014) The Good research Guide for small-scale social research projects. 5th ed. Maidenhead, Open University McGraw Hill

Department of Health (2008) *End of Life Care Strategy. Promoting high quality care for all adults at the end of life*. London: Department of Health

Department of Health (2014) *Actions for End of Life Care: 2014-16.* [Online] Available from: https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf [Accessed 10.06.17].

Dhalivaal, J. (2011) Patients' perspectives on prescribing by nurses in general practice. *Practice Nursing*, 22 (1), 41-46

Downer, F. & Shepherd, C.M. (2010) District nurses prescribing as nurse independent prescribers. *British Journal of Community Nursing*, 15 (7), 348-52.

Gadamer, H-G. (1975) Truth and Method. Translated by Weinsheimer and Marshall (2006), New York, Continuum

Glaser, B. & Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research.*London: Aldine Transaction

Heidegger, M. (1962) Being and Time. Translated by Macquarrie, J & Robinson, E. Oxford, Blackwell Science

Latter, S., Blenkinsopp, A. Smith, A., Chapman. S., Tinelli, M. Gerard, K. Little, P. Celino, N., Granby, T. Nicholla, P. & Dorer, J. (2011) *An Evaluation of nurse and pharmacist independent prescribing. Final Report for the Department of Health*. University of Southampton and Keele University.

National Institute for Health and Care Excellence (NICE) (2015) *Care of dying adults in the last days of life* [online]. Available @ https://www.nice.org.uk/guidance/ng31 [Accessed 10.06.17]

Offredy, M. & Vickers, P. (2010) *Developing a Healthcare Research proposal. An interactive student guide,* Chichester, Wiley-Blackwell

Parahoo, K. (2014) *Nursing research, principles, process and issues* 3rd edition. Basingstoke, Palgrave Macmillan.

Polit, D. & Beck, C. (2014) *Essentials of Nursing Research. Appraising Evidence for Nursing Practice*. 8th edition. Philadelphia, Lippincott, Williams and Wilkins.

Polit, D. & Beck, C. (2017) Nursing Research: Generating and assessing evidence for nursing practice. 10th edition, International edition, Philadelphia, Wolters Kluwer

Rowbotham, S. Chisholm, A. Moschogianis, S. Chew-Graham, C. Cordingley,L. Wearden, A. & Peters, S. (2012) Challenges to nurse prescribers of a no-antibiotic prescribing strategy for managing self-limiting respiratory tract infections. *Journal Of Advanced Nursing,* 68 (12), 2622-32

Ryan-Woolley, B., McHugh, G. & Luker, K. (2008) Exploring the views of nurse prescribing among Macmillan nurses. *British Journal of Community Nursing*, 13 (4), 171-2, 174-7

Thomas, G. (2013) *How to do your research project,* 2nd edition. London, SAGE Publications Ltd.

Twycross, R and Wilcock, A (2016) *Introducing palliative care*, 5th edition. Nottingham, Palliativedrugs.com Ltd

van Manen, M. (1990) Researching lived experience: Human science for an Action Sensitive Pedagogy. London, Ontario; Althouse

Webb, W. & Gibson, V. (2011) Evaluating the impact of nurse independent prescribing in a weekend clinical nurse specialist service. *International Journal of Palliative Nursing,* 17 (11), 537-543

World Health Organisation (2015) WHO definition of palliative care. [Online] Available from: http://www.who.int/cancer/palliative/definition/en/ [Accessed 10.06.17]

Young, D., Jenkins, R. & Mabbett, M. (2009) Nurse prescribing: an interpretative phenomenological analysis. *Primary Health Care,* 19 (7), 32-36

Appendix 1: inclusion and exclusion criteria

Further studies were found by referring to the reference lists of journal articles. See Table 1 below for inclusion/exclusion criteria.

Table 1: Initial inclusion/exclusion criteria for literature search.

Inclusion criteria	Exclusion criteria
Written in English	Not written in English
Published in peer reviewed journals	Not peer reviewed publications
Carried out from 2006 onwards	Carried out prior to 2006
Based in the United Kingdom	Based outside of the United Kingdom
Palliative care settings	Secondary care
Community based care provision	Other in-patient units