

An Exploration of Community Palliative Care Clinical Nurse Specialists Experiences of Working as Independent Prescribers: Part

2

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An exploration of Community Palliative care clinical nurse Specialists experiences of working as Independent prescribers part2

Main themes	Sub-themes
Perceived benefits of nurse independent prescribing	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

PART 1

Discussion of main themes and sub-themes

Perceived benefits of nurse independent prescribing:

There are five sub themes within this main theme.

Helping patients in times of crisis:

All six participants in this study reported that being able to prescribe independently for patients led to effective symptom management among palliative care patients. Being able to access medication quickly, particularly if the patient was near to the end of their life, was the most significant perceived benefit of being an independent prescriber. One participant captured this when stating:

“Symptom control (is) so much smoother, timely, I (don’t have to) chase round after the out of hours GP service to try and get a prescription...” (P1).

Another participant commented:

“You haven’t got to go through a third party..... You can actually write out the prescription sheets for the district nurses and sort of do everything” (P6).

From the above, the benefits focus on how the process can be expedited in order to improve patients’ situations and experiences in the palliative care phase.

Being available when others aren’t:

Five of the participants worked at weekends and two of these reported that it was during this period that non-medical prescribing had the most significant impact on patients. When asked how being able to prescribe had affected her role as a community palliative care CNS, one participant was emphatic in her answer:

'Mainly weekends, bank holidays that it prevents us having to call out the out of hours doctors. Um, it helps with increasing dosages of medications rather than having to get things authorised or wait for a GP to speak to or wait for out of hours' (P4).

The quote above demonstrates the importance of reviewing the patient as pain and other symptoms may escalate as the disease progresses (Twycross and Wilcock, 2016).

One respondent (P1) expressed the view that it was safer for the NIP to prescribe at weekends because she had access to patients' details that an out of hours doctor may not have:

"....if you have a choice between a specialist palliative care practitioner who happens to be a nurse who has all the information on the computer and all the back ground and is their specialism, their area of expertise, balance that up with, you know, the out of hours GP service which is very stretched, is challenged by not having access to the data that we do...." (P1)

However, working at weekends did present challenges for one of the nurses (P6) in that she would be contacted by the district nursing teams specifically to prescribe for a patient. This appeared to cause a dilemma because, although she did not want the patient to experience uncontrolled symptoms, she had to prioritise over which visits were most important.

Gaining satisfaction from being able to provide holistic care:

Participants described how being able to prescribe enabled them to provide holistic care and that this was more convenient for the patient. An added consideration discussed by one participant (P3) was that, rather than asking a doctor who may not have reviewed the patient to prescribe for them, the nurse could follow through on her prescribing decisions based on her assessment of the patient at that time, therefore offering continuity of care:

"you're not waiting for, you know, your medics to come and do your prescribing, you can do it as an autonomous practitioner, right from seeing the patient and if they've got an instant need you

can prescribe and administer and so that's probably the most crucial aspect of it- continuity of care..." (P3)

Knowledge to prescribe the right medicines at the right time:

There was a suggestion made by two of the participants that the doctor may not have the specialised knowledge that they have, especially during the out of hours' service, as such doctors are often locums. However, this uncertainty of the medical team's expertise was not limited to the out of hours' period:

"...we do have some GPs who, with the best will in the world, if we didn't do it, the patients wouldn't get it done, wouldn't get good symptom management" (P2).

This viewpoint was not shared by all participants, with one particular respondent (P5) expressing the view that the GPs she worked with had a good knowledge of symptom management

Increased knowledge of pharmacology:

One participant highlighted medicines management as a specific benefit of being able to prescribe independently in that it gave her the knowledge required to rationalise medicines (P2). Another suggested that it is knowing when not to prescribe as well as when to prescribe:

"...I think that's the biggest thing I took, one thing I took from the prescriber's course, it's not all about prescribing, it's about not prescribing.." (P2).

This response is important because it illustrates that this nurse, supporting patients who may be nearing the end of their lives, is considering the burden that these patients can face, of taking medication.

Carrying out a holistic assessment before considering differential diagnoses when assessing the patient was considered important and identified by four participants. This is illustrated by the comment made by P3:

“I think that it makes me really think about what’s going on with my patients, you know I mentioned about renal function and liver function, it makes you really look at the wider picture and the ifs and buts it’s not just about number crunching because one simple prescription can make a real difference to somebody or you can do a dozen prescriptions and they never use them you know, ultimately...” (P3).

Educating patients was mentioned by two participants (P1 and P2) and being able to advise health professionals by one nurse (P3).

One participant felt that having a prescribing qualification was an essential requisite of her role:

“I can’t imagine how anyone can do our jobs without being a prescriber now. It makes me wonder, even though, like I said if you’re knocking on doors and asking things, it has given me another layer of knowledge and the other side of it is, if you’re advising people you should have that knowledge. How can you be asking for stuff that you don’t fully understand?”(P3).

Barriers relating to prescribing practice

There are four sub themes under this main theme.

Anxiety of writing prescriptions incorrectly:

This was a source of anxiety highlighted by four participants (P2, P4, P5, P6) and below we only use two to illustrate the point:

In relation to the worry *'...yes you did a few dummy prescriptions but actually the stuff that we prescribe like the controlled drugs, there's a special way to write them you know and its all of that and it's the learning of the vials'* (P2).

The actual worry *"...it was the actual physical writing the prescription and writing it wrong"* (P5)

The anxiety associated with writing the prescription incorrectly was sometimes compounded by the distractions associated with prescribing in the patient's home and participants described how difficult it could be explaining to the patient and family that they needed space and quiet to concentrate:

"Um, I used to say to the relatives, I'd say look I need to concentrate for a few minutes now..." (P5)

"...but I do think its very different in a home because it often can be noisy and there's all sorts of things so, so that's the difficult bit, getting a little space and say I really need to concentrate on this" (P2)

Participants could recall the first prescription that they had written as illustrated by this nurse:

"I felt prepared, I felt excited, but I also felt petrified. Yes, the first prescription I sort of double checked, triple checked and I also rang the pharmacist afterwards to make sure I'd done it right" (P5)

The fact that these events could be recalled so vividly, gives some indication of the significance to these nurses of being able to prescribe and also the realisation that they were ultimately accountable for their actions.

Participants described the delays that they experienced in gaining access to prescription pads, with one participant waiting six months to receive her pads. They described the negative impact that this had on their confidence to prescribe as this participant illustrates:

'...waiting so long (for prescription pads)....I think it is confidence, yes most definitely, cos you think that it's never going to happen really' (P4)

Although this led to feelings of frustration for one nurse (P1), it did not prevent participants from prescribing when they were able to do so.

One participant described how 'scared' she was when there were initial recommendations for palliative care services to provide support for all patients, not just those with a cancer diagnosis. She explained that they were receiving more referrals for patients without cancer but suggested that their 'long learning curve' may be addressed by more joint working with nurses from other disciplines. Half of the participants expressed a fear of loss of confidence if their skills were not maintained. One of the participants described how she 'makes' herself prescribe so that she doesn't lose the skills that she's gained:

"And that's why I makeeven if its paracetamol, I try to a little bit, you know, regularly so I don't lose the skills.... and I want to keep it up" (P5)

The accounts described above illustrate how the participants in this study, although sometimes experiencing uncertainty in their prescribing ability, often developed pragmatic solutions to overcome these anxieties.

Inadequate knowledge and negative/unfavourable attitudes of other health professions:

Despite nurses having authority to prescribe as nurse independent prescribers since 2006, it appears that not all health professionals are aware of this. For example, a local pharmacist wrongly informed p5 that she was not allowed to prescribe controlled drugs, which resulted in p5 being frustrated and reporting during the interview that such comments affected her relationship with the patient for whom she was prescribing leading to loss of trust:

"...it did cause a lot of upset to the family because they were like -why did you prescribe it if you're not allowed to prescribe it but...but I always say to patients, I'm prescribing, I'm allowed to prescribe

but if you have any problems, because since then I've just sort of tried.... more for their point than mine, because if they think that there's someone randomly going around prescribing things when they're not allowed to..." (P5).

All six respondents felt that they had a positive relationship with the GPs that they worked with. One participant (P6) felt that, although generally relationships with GPs were good, there was some opposition to nurse independent prescribing, particularly in relation to anticipatory prescribing. A possible lack of confidence in the nurses' abilities by the GPs was also discussed by another participant (P2). She described having to put systems in place to ensure that the GPs with whom they were working did have confidence in their abilities:

"when I went ... into community um we did have some barriers and think that's why we put so many systems in place to actually make sure that they (GPs) felt confidence but then I think with some GPs they then tried to abdicate all responsibility to us..... They want us to do it because they know that we're safe'. '....if you're working with a set of GPs they start to feel very confident – (they say) actually these know what they're doing...." (P2)

This was supported by another participant who said that she would have been surprised if there had ***been*** any resistance to nurses prescribing, especially during the out of hours period:

"....actually there was no resistance from the GPs because they could also think well we could have an out of hours GP who has got no information on this patient making decisions and again possibly no interest in palliative care or we can have aspecialist nurse who's got the information on file and this is their area and they can prescribe" (P1).

The majority (four) of the participants felt that their nursing colleagues were supportive of their prescribing role. There appeared to be more supportive where there were other prescribers within the team although one lone prescriber (P4) did feel that the rest of the team did appreciate her role and probably all wanted to undertake the prescribing course in the future.

Another lone prescriber appeared to take a pragmatic view on possible opposition to the role. She acknowledged that not everyone supports non-medical prescribing but felt that this negativity could be used in a positive way to ensure that their practice is as safe as it can be:

“There is that school of thought out there and they are entitled to their opinion and, but I think, you know, its opinions like that, I think that actually sharpen us up as prescribers; rather than taking that as negatively I’ve always taken that as a, yes, as a tool really” (P1).

Team working was highlighted as being important by three of the six respondents and included working closely with nurses from other specialities (P2) and allied health professionals (P6).

Inadequate access to patients’ notes:

This was a real concern for participants as they felt patients were not always able to give a full history of their illness and may have other co-morbidities that needed to be considered when prescribing for them. Although it is of obvious benefit if the GP surgery provides detailed information about the patient, sometimes it was inadequate:

“you’ve sometimes got limited information... their (GPs’) notes come through like a summary, those can be helpful at times. Other times it’s just lists going back years of medicines that have been prescribed” (P6).

The same participant also raised concerns about the potential for confusion if there were multiple prescribers all prescribing for the same patient.

One solution to the difficulties associated with accessing patients’ records suggested by several participants was having a shared computer system with GPs. It was also felt that this would reduce administrative time, enabling GPs to be notified of prescribing decisions sooner. Two respondents did have shared computerised notes and clearly found this to be beneficial, however, one nurse (P6) who

covered several GP practices, commented that not all these surgeries were using the same system. Even when there was a shared computer system there were logistical difficulties: although medications could be added to the patient's record, changes to the doses of drugs prescribed by a GP could not be recorded in the same way.

There was recognition from some participants that writing prescriptions electronically is faster than writing scripts out by hand. This was further enhanced by having an agreement with the local pharmacy to ensure the prescribed medication reached the patient in a timely manner. She suggested that writing a prescription in the patient's home may not be the best option for that person, particularly if they live alone:

"I'll speak to the GP because I think at least then it's all done on the computer, they're on repeat prescription....and we've got good pharmacy communication and delivery systems.....if they (the patient) are on their own, they're elderly and they haven't got anyone to take the prescription in, we haven't always got time to drop the prescription off, we can't do it" (P4).

One participant felt that this facilitated discussions with the GPs and, even though she was able to prescribe, did not feel pressurised into doing so:

"What I usually say is I can do it, you know I'm a prescriber, I can do it....at this one surgery, because they have the pharmacy through the door, so they say, no that's fine we'll do it....it's just a push of the button and they've done it" (P5).

This quote clearly illustrates some of the complexities that are faced by nurses supporting patients

Impact of prescribing on role:

Three of the six nurses felt that being able to prescribe was time consuming due, in part, to lengthened consultations and the administrative component of the role. However, two of these three then went

on to explain that, although it is time consuming, it actually makes better use of their time in that it avoids having to contact GPs to ask them to write prescriptions. In total, four of the six participants felt that prescribing for patients saved time as explained by this participant:

“I would say that it makes my time management more efficient all round because you’re assessing, seeing that patient, prescribing, its, they’re ready sort of to deal with.... but I would say, all in all, it has been a time benefit for everyone” (P3).

One participant (P5) felt that being able to prescribe had had very little impact on her role. However, this particular participant did not work at weekends and felt that the GPs’ symptom management was good. Another participant (P4) also rarely prescribed during normal working hours as she felt it was so much easier for the GP to prescribe as they have access to computerised prescriptions and it enabled the medication to be added to the patient’s record straight away.

Reflections on the nurse independent prescribing (NIP) course:

In relation to how prepared they felt to prescribe after completing the nurse independent prescribing course, four of the six participants felt that the course was not specific enough to palliative care. One participant used an analogy to becoming a mother when describing how prepared she felt on taking on the prescribing role:

“.... in some ways it’s like motherhood I think, you feel adequately prepared and then it happens and I think oh my goodness, this is bigger than I thought...” (P1).

Another likened it to a driving test:

“It’s like learning to drive and then the first time you actually go out without someone sat by you...” (P5)

Both of these quotes seem to suggest that, although they felt ready to prescribe, they found the reality of prescribing very daunting.

Unlike earlier studies, none of the participants reported that they felt inadequately prepared to prescribe, after completing the course.

Views about recommending role to others:

Participants' views varied on whether they would recommend the role to their colleagues. Two participants (P1, P5) felt that the nurses themselves must want to do the course of their own volition rather than being persuaded to by others. Other participants felt it made a significant difference to their practice and would encourage others to become NIPs:

“Yes I would (recommend the role) because I think we’re safe, I think I’m safe, I think it does make a measurable difference to our patients and from talking to our medical colleagues they certainly think that it’s cost effective”(P3)

Another participant went so far as to say that she felt that all CNSs should be able to prescribe because decisions are then made based on the outcome of the nurse’s assessment at the time and not passed to a third party i.e. the GP, to prescribe medications when they themselves may not have reviewed the patient.

One participant, who belonged to a team where NIPs were in the majority, was very keen for others to take the course. She summarises all that nurse independent prescribing was set up to be:

“I think that its, its more for patients, you know. If you put the patient at the centre of things, what the patient needs, when you look at the history of nurse prescribing it was about making it better for patients and I actually think it does and it's not that I want to exclude the medical team at all it's about getting it right for patients and we only get one chance don't we... ” (P2).

Discussion

The Department of Health (NICE, 2015) has emphasised the importance of patients having rapid access to medicines at the end of their lives. The majority of the participants in this study felt that their prescribing practice had the most impact at weekends, increasing continuity of care and preventing delays in obtaining medication by avoiding the need for patients to call the out of hours doctor, a process that could take many hours. This has not been identified in previous studies. The practice of CNSs working at weekends is relatively new and it may be that the studies were carried out before this time and therefore do not reflect this. The one participant in this study who felt that prescribing had little impact on her role did not work at weekends and this would, therefore, support this conclusion.

All of the participants in this study described the importance of being able to provide holistic care for their patients and they believe that being able to prescribe independently helped them to achieve this. This is supported by previous studies (Brodie et al, 2014; Ross and Kettles, 2012; Cousins and Donnell, 2012). One participant felt that, having assessed the patient, it was safer for her to prescribe medication based on that assessment rather than asking the GP to prescribe. The logic here is continuity and speed of getting the medication to the patient and control notorious symptoms

Five out of the six participants in this study discussed increased knowledge of pharmacology as a benefit of being able to prescribe. Although medicines management, now referred to as medicines optimisation (NHS England, 2015) was only mentioned by one participant, when it's meaning is considered, namely ensuring that patients have the right medicines at the right time, it is clear that all six participants utilised this. Ultimately the patient's outcome and experiences can be improved.

Although two of the participants felt that it was important that nurses were not persuaded to become prescribers, two of those interviewed felt that it was essential that all CNSs were able to prescribe. The palliative care CNS who is not a prescriber is able to advise patients and their families, as well as

other health professionals. However, they are unable to adjust doses of medicines. Further research may discover the views of other practitioners regarding this issue.

Fear of prescribing errors have been identified in previous studies (Ziegler et al, 2015; Cortenay et al, 2012; Downer and Shepherd 2010) and are supported by the findings of this study. This is demonstrated by how participants described the concern that was provoked by knowing that the patient may not be reviewed until the next day. The underlying anxiety is based on what a drug error can mean for patient outcomes. This resulted in some participants going to great lengths to ensure that they had prescribed correctly.

The participants in this research described several strategies that they used to reduce this anxiety such as keeping to a limited range of medicines to begin with. It is difficult to know whether altering the content of the prescribing course would have any impact on reducing these concerns as, although there were concerns that the course was not specific enough to palliative care, the majority of respondents did feel adequately prepared to undertake prescribing. Benner (1984) describes how, when a new skill is learnt or a nurse commences a role that they are not familiar with, the practitioner becomes a novice in that area. Although the prescribing course ensures competence to prescribe, it is impossible to teach the intuitive ability that comes with experience or being an expert. It can be argued that anxiety relating to any newly acquired skill is normal and to be expected. A further argument is that such anxiety is beneficial as it can help the practitioner to keep a high level of focus and concentration which helps to ensure safe practice and minimise prescribing errors.

Palliative care is for all patients with a life-limiting illness, not just those with cancer. However, it has been suggested that one of the key challenges in palliative care is providing support for patients with other conditions due to differences in disease trajectory (Murray et al, 2010). One of the participants in this study described her uncertainty regarding prescribing for patients with a non-cancer diagnosis. This was also highlighted by participants in Cole and Gillet's (2015) evaluation but not in the other studies that were critiqued. Developing closer working relationships with CNSs in other disciplines

such as heart failure and neurological conditions, may increase the confidence of palliative care CNSs and improve symptom management for these patients.

One participant described the opposition by some GPs to non-medical prescribing, particularly in relation to anticipatory prescribing. Concerns regarding anticipatory prescribing at the end of life have been addressed by the British Medical Association (2012). This would suggest that the concerns expressed by the GPs who worked alongside the participants in this study are shared by others. Therefore a way forward is needed.

Opposition towards nurse independent prescribing by other health professionals has been highlighted in previous studies (Gumber et al, 2011; Downer and Shepherd 2010; Bradley and Nolan, 2007). It was encouraging, however, to find that all of the participants in this study had a good relationship with GPs and felt well supported. In addition, participants generally found their nursing colleagues to be supportive. The pragmatic approach to prescribing that is apparent from this study is illustrated by one of the participant who used negativity towards the role in a positive way by being determined to be a safe and effective practitioner.

One participant interviewed felt that it was safer if the GP prescribed as it could be entered straight onto the patient's record. The difficulties associated with access to patients' records is well documented (Cole and Gillett, 2015; Smith et al, 2011; Downer and Shepherd 2010; Stenner and Courtenay, 2007; Hall, 2006) and is a specific concern associated with supporting patients in the community. Despite Hall's (2006) study identifying these concerns a decade ago, it would appear that Clinical Commissioning Groups and palliative care providers have some way to go before this issue can be resolved. Several participants suggested that shared computer systems would help to rectify the difficulties associated with accessing patient records.

The ease with which GPs are able to prescribe was highlighted by two of the participants in this study and this did influence them in deciding whether to prescribe or not. Both electronic prescribing and

forwarding prescriptions to pharmacists electronically for patients who have specifically requested it is becoming more common place and may negate the need for nurses to prescribe in certain circumstances. It was not possible to extrapolate from this study whether nurses were more or less likely to prescribe depending on whether the area they covered was urban or rural.

The findings from this study are consistent with previous findings in some aspects, but they also raise new questions and areas that need improvement in order to benefit patient outcomes.

Conclusion

The lived experiences of clinical nurse specialists in this study highlighted both the benefits of being able to prescribe independently and the barriers that participants encountered during their prescribing practice. The benefits were about enhancing patient's quality of life while barriers need to be eliminated in order to improve medication management for all patients. The use of an interpretative phenomenological (IP) methodology was preferred as it did not only allow the researchers to gain an insight into the perceptions of these nurses, to also use researchers' prior understandings to interpret participants' experiences across the West Midlands, in a way that has not been demonstrated in previous studies.

Strengths and limitations

One of the strengths of this study is that the participants were based at different locations and employed by different organizations across the West Midlands. Although this is a small study, the number of participants is considered to be sufficient for interpretive phenomenological research with intentions of transferability of findings. In other words, because the participants are all nurse independent prescribers employed as community palliative care clinical nurse specialists, the sample is very specific and may, therefore, be transferable to other parts of the UK which have a similar management structure and prescribing tendencies.

One of the weaknesses of all qualitative studies, IP included, is that the conclusions made are subject to the interpretation of the researcher. Rigour may have been partially strengthened by the transcriptions being read and interpreted by a second researcher. Partial strength in that the second research missed the atmosphere in which each of the six interviews were conducted with the accompanying non-verbal cues also having been missed. It is hoped, however, that including direct quotes from participants has increased the credibility of these findings.

Implications for practice

The results of this study demonstrate that, despite nurses being able to prescribe independently since 2006, there are still physical and psychological barriers to their prescribing practice which need to be addressed if this valuable qualification is to be fully utilized. Although little can be done to change the attitudes of health professionals who fundamentally do not agree with nurse independent prescribing, changes to the ways in which community nurses access patients' records would not only encourage them to prescribe by making prescribing decisions easier to record, it

would also enhance patient safety. Introducing mentoring for newly qualified prescribers by experienced NIPs may help alleviate some of the anxieties associated with the role.

Recommendations for future research

- Further qualitative research is suggested to explore whether the experiences of the NIPs in this study are similar to those of nurses in similar roles in other areas of the United Kingdom.
- Qualitative studies to investigate the views of patients and their families receiving palliative care in relation to nurse independent prescribing would help to inform healthcare providers in order to shape services in the future.

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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

