

# Pharmacist Prescribing within a Palliative Care Service

Jo Noble-Gresty, Palliative Care Specialist Pharmacist  
Dr Anne Naysmith, Consultant in Palliative Medicine  
Pembroke Palliative Care Centre

Amsterdam  
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# Integrated Specialist Palliative Care Service

- In existence since 1893
- Inpatient unit, Day Care and community support team from single base
- Catchment area involves parts of 4 PCTs
- Traditional “advisory” service outside the inpatient unit, ie we advise, GP prescribes (hopefully as advised!)

# Role of the Specialist Pharmacist

- Truly a specialist pharmacist!
  - Medication reviews at consultant ward round weekly + regular input
  - Responsibility for written symptom control guidelines, updated at least biennially
  - Education of SpRs in palliative medicine
  - Input to Supportive and Palliative Care Network

# Why keep a dog when you can bark better yourself?

- Pharmacist has established track record of knowledge and skills
- Single handed consultant accustomed to carrying the risk of delegation with a light touch
- Asking GPs to prescribe on advice wastes staff and patient time, adds to overall NHS costs, and denigrates GP's skills while not improving ours!
- Palliative care light on diagnosis, heavy on titration

# Preparatory Work

- Think through the role to make sure it actually “adds value”
- Negotiate acceptance from colleagues, especially in community team
- Apply for charitable funding to back fill pharmacist time
- Set up definitive evaluation, to justify use of funding

# Specific roles envisaged

- Take over routine titration (eg gabapentin)
- Symptom control in well diagnosed situations, eg opioid side effects, nursing homes
- Support CNSs and junior SpRs
- Medication reviews/concordance at home

# Dangers envisaged

- Lack of anatomy, physiology, biochemistry and clinical medicine
- No training/experience in physical examination
- No ability to diagnose
- Tendency to (mis)use SP as a junior doctor!

# Ongoing work

- Supervision during training
- Agreeing Clinical Management Plans
- Support to the SP so that she actually prescribes (like swimming, getting in is the hardest part!)
- Regular review to ensure role boundaries are maintained

# Developing the role

- 13 years experience in Palliative Care
- MSc in pain management 2004
- Supplementary Prescriber July 2005  
Natural extension of prescribing advisory role

# Potential areas

- Inpatients  
14 beds, funded for 290 admissions per year
- Daycare patients  
Currently 44 patients attend over 4 days a week
- Homecare patients  
Currently 175 patients looked after by a Consultant, a Specialist Registrar and 9 Clinical Nurse Specialists over 4 PCTs
- Nursing home patients  
In 2 nursing homes

# Current Supplementary Prescribing Activities

Funded for 12 hours per week

- Consultant ward round
- Inpatient unit Multidisciplinary Team Meeting
- Palliative Care patients in nursing homes
- Homecare Multidisciplinary Team Meetings
- Home visits
- Education and training

# Palliative Care patients in nursing homes

- 2 nursing homes
- Consultant visits weekly
- Alternate week visits with Consultant by CNS and Pharmacist
- When Consultant away visit alone or with CNS
- Available to visit at other times as required
- Support for nursing staff

# Palliative Care patients in nursing homes

- Since December 2005 - 34 patients
- Clinical Management Plan for symptom control and patient comfort
- Prescriptions (inpatient and FP10) for medication review, analgesics, laxatives, anti-emetics, general symptom control, end of life care, rewrites

# Palliative Care Patients in nursing homes

- SP, male, 83 years

Advanced vascular dementia, Parkinson's disease, CVAs, Type 2 DM, recurrent UTIs

- 26<sup>th</sup> April 2006 referred to PC team seen by Consultant and CNS

**Appears to be entering terminal phase, sleeping comfortably, not distressed, passing urine, still able to swallow**

- Rx Aspirin 75mg od, ISMN 60mg od, Atorvastatin 10mg od, Sodium Valproate MR 500mg od, Paracetamol 1g QDS prn, Diazepam 5mg PR prn

# Palliative Care Patients in nursing homes

- 2<sup>nd</sup> May seen by GP

4<sup>th</sup> day without fluids

Rx Dextrose 5% 1 litre by SC infusion over 24 hours

- 3<sup>rd</sup> May seen by JNG

Sleeping soundly, unresponsive

Spoke with daughter to obtain consent to prescribe

Issue of hydration and sedation raised by daughter

- Deteriorating condition

Clinical management plan for symptom control and patient comfort

# Palliative Care patients in nursing homes

- Oral medicines stopped

Rx NaCl 0.9% 1 litre SC infusion over 24 hours for 2 days

Midazolam 2.5mg SC prn 2 hourly (Diazepam 5mg PR prn Rx)

Paracetamol 1g PR prn QDS (po Rx)

- Supply of Midazolam injection and Paracetamol suppositories arranged
- Asked Consultant to speak to daughter about hydration
- Patient died peacefully on 5<sup>th</sup> May

# Audit of supplementary prescribing

- Dec 2005 to Oct 2006 - 23 patients  
Clinical Management Plans in 65%  
Prescriptions in 48%
- 6.75% of total prescription orders by the PC team  
34 prescriptions: 31% for pain, 18% for GI disorders,  
12% for nausea and vomiting
- 58 interventions, 81% preventing morbidity

*Kishan Thakerar, A Retrospective Audit of a Pharmacist Supplementary Prescribing Service in Palliative Care, King's College London, March 2007*

# Homecare patients

- Homecare multidisciplinary team meetings for 4 PCTs  
– currently 175 patients
- Medication review, drug interactions, dosing in renal impairment (Gabapentin, Zoledronic acid), TDM (Phenytoin)
- Advice on choice of therapy for specific patients
- Home visits
  - Poor concordance due to confusion over regime
  - No supply
  - Symptom review

# Benefits to patients

- Continuity of care
- Access to medicines
- Value-added service
- Risk management

# Lessons learnt

- Slow but steady progress
- Evolving role
- Previous working relationships and integration within a team have made it workable  
Supportive Independent Prescriber keen to allow role development
- Documentation  
Clinical Management Plans, Information for patients and relatives, Medical notes, Palliative Care notes, Patient information records

# Challenges

- Changing role  
For other healthcare professionals and patients
- Barriers
- Time management
- Development of skills  
Consultation and clinical
- Patient consent issues

# Looking forward

- **Role expansion**  
Homecare – home visits  
Daycare and nurse led clinics – medication review
- **Independent prescribing**  
But **no** Controlled Drugs!  
Inpatients – discharge medicines, review of therapy, amendments
- **Consultant pharmacist**  
Maintaining practice base without management responsibilities

# The benefits

- A pharmaceutical dimension to everything we do
- Specific services, particularly to the nursing homes, more cost-effective
- Development of a valued team member

# Will Independent Prescribing Add More?

- Probably – depending on the medical consultant involved
  - Issues because of large number of CDs in palliative care prescribing
- Stress level for pharmacist will have to be supported and managed
- Independent prescriber will need review and supervision as a clinical specialist
  - Implications for consultant time