Creating a tool to improve anticipatory prescribing in palliative care

Anticipation is the hallmark of good palliative care prescribing. Aileen Scott-Aiton describes a simple tool that can be used in both primary and secondary care to improve the prescribing of “when required” medicines in the event of a patient’s condition deteriorating.

Unexpected symptoms may develop at any stage in a terminally ill patient, and one of the hallmarks of good palliative care is to anticipate the problems and plan accordingly. In the Scottish Borders, we have developed a preprinted chart of “when required” medicines for patients with palliative care needs. A list of the medicines that are commonly used in palliative care in the Scottish Borders, their doses, frequency of dose and total maximum daily dose can be seen in Figure 1. These medicines are incorporated into a chart to form the tool that sits in the “when required” section of the patient’s medicines chart (Kardex), although it could stand alone when not using a Kardex in the community. The tool is designed to improve anticipatory prescribing, thus ensuring that drugs are already prescribed to meet the needs of the patient. Any primary care trust could adapt the chart for its own use, incorporating its own choice of medicines and doses.

Identifying the need
As identified by Amass and Allen (PJ, 2 July 2005, p22), we also found that patients in both primary and secondary care were encountering symptom-control problems, which were exacerbated by insufficient anticipatory prescribing, especially out of hours. The Scottish Palliative Care Pharmacists Association frequently debates anticipatory prescribing and how it can be improved, highlighting a national need for such a tool.

Development
Identifying this problem prompted us to draw up a check-list of “when required” medicines that doctors should prescribe (Figure 1). This would be especially useful at the weekends and at night, when there are no specialist team members available to give advice. To ensure that all patients had access to the drugs on the check-list, it was decided to preprint a chart listing them, which would supplement the hospital Kardex. When the check-list in Figure 1 is used as a chart, the doctor will sign on the right-hand column next to which medicines he or she wants to prescribe. The back of the chart consists of instructions on how to complete it. This tool was then piloted successfully in the palliative care ward of the district general hospital, and in one of the community hospitals. In fact, health professionals found it so useful that they wanted to adopt it in other areas before the pilot was complete.

The Scottish Borders Health Board uses patient-held palliative care Kardexes in the community, as well as in the hospital environment. Because this Kardex can be started in the community and goes with the patient wherever he or she goes, it allows a nurse, on the patient’s admission to hospital, to administer a “when required” dose immediately, so long as it has previously been signed by a doctor. This prevents the delay of having to find a doctor to prescribe it.

Likewise, if a patient is discharged from hospital into the community, a district nurse or community hospital nurse may administer any drug written up in the Kardex or on the “when required” chart since this is an official prescription.

Figure 1: A list of the medicines that are commonly used in palliative care in the Scottish Borders, their doses, frequency of dose and total maximum daily dose.
Although introducing the tool to health-care professionals required little effort (it is fairly self-explanatory), it does provide nurses and doctors with an educational opportunity and a chance to address any problems that they may be experiencing. To reinforce the education, the following instructions are printed on the reverse of the tool:

- Sign and date as many drugs as may be required at any time by the patient in the future (no nurse is going to administer levomepromazine, for example, until it is required).
- Delete any drug that will never be used (eg, levomepromazine in patients with a risk of seizures, or stimulant laxatives in bowel obstruction).
- Delete either cyclizine or metoclopramide since cyclizine has an antagonistic effect on metoclopramide.
- Delete a drug if the maximum daily dose is already prescribed as a regular medicine (eg, cyclizine 50mg prescribed three times a day).
- Now that midazolam is a schedule 3 Controlled Drug, doctors must complete the dose and the maximum total daily dose rather than have them preprinted.
- If unsure about a drug, do not sign it (but it may be signed at a later date).
- Delete an item if you wish to use a different dose, and write up the item and new dose in the Kardex.
- If an item has been deleted from the chart, it may still be used later if rewritten in the Kardex.
- When discontinuing a medicine, put a double-score after the last administration of that medicine, sign and date it.

The Kardex has now been reprinted with the preprinted chart incorporated into it. The advantages of using this prescribing tool include:

- Patients get prompt relief of their symptoms and it allows better patient care out of hours.
- It empowers nurses to give a drug when they recognise the need, thus speeding up the relief of symptoms for patients (this is particularly useful in community hospitals).
- It saves doctors’ time when writing up a Kardex.
- It allows patients’ own GPs and district nurses to plan continuity of care out of hours since many primary care teams take particular interest in looking after their patients at home.

Concerns

The only problem we have had is occasional duplication of prescribing on the tool and the Kardex. When signing the tool, care must be taken to ensure that none of the medicines is already written on the Kardex. However, in the community, a nurse would usually alert a colleague at hand-over time that he or she had given a dose of “when required” medicine and ask the colleague to watch the response, so the risk of duplicating a dose is small. In the hospital, a pharmacist routinely checks the Kardexes.

Feedback from healthcare professionals

The feedback has been positive and has reflected the enthusiasm for this tool in both primary and secondary care. Some of the comments include:

- It is absolutely wonderful to be able to administer drugs without first having to find a GP to write them up, especially hyoscine, which has seldom been prescribed in anticipation before. This is long overdue. — Community hospital nurse.
- Why can’t we use it in the community too? — GP using the chart in the pilot community hospital, before its use in the community.
- Wonderful. It not only acts as a prompt, but saves us so much writing. — Junior hospital doctor.
- This is just what we needed. I was so upset recently when I knew what a patient needed, but had no prescription or medication to allow me to administer it — District nurse, on hearing about the chart but before it was rolled out to her area.

Conclusion

This tool facilitates anticipatory prescribing and provides a useful educational opportunity for health professionals. It also meets a need to improve symptom control, especially out of hours. Because it is simple to put into practice and is both time- and labour-saving, it has been well received by healthcare professionals throughout the region.

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We suggest that this tool is used in conjunction with anticipatory packs of the “when required” medicines needed at the end-stage of life, such as the “just-in-case” boxes recommended in the gold standards framework (and already adopted by a number of primary care trusts).

These packs may contain as many of the drugs listed on the chart as each practice deems appropriate. This tool may be initiated at any time during a patient’s illness, but it is especially useful together with the “just-in-case” boxes at the end of life. We will act on the “local authorisation document” recommended in the gold standards framework.

The packs are held in a practice until such time as a patient deteriorates and may need some of these drugs, then the whole pack is transferred to the patient’s home. There are, however, no CDs in this tool, so these must be prescribed in anticipation in the traditional way. In the Scottish Borders, the out-of-hours doctors are also encouraged to carry their own morphine. Having the medicines in the patient’s home, along with a completed anticipatory prescribing tool, allows a nurse to administer the drugs with minimum delay.

Audit

We have done a retrospective base-line audit of anticipatory prescribing in the pilot areas at the moment, and it would appear that, before the introduction of the tool, there was little anticipatory prescribing done. We will carry out the second part of our audit in due course to measure whether there are any improvements with the introduction of the anticipatory prescribing tool.

Roll-out programme

After such a successful pilot, when we experienced no problems, we rolled the package out to the whole of NHS Borders, where it has been received with enthusiasm.