Macmillan Rural Palliative Care Pharmacist Practitioner Project

Mapping of the Current Service & Quality Improvement Plan

Executive Summary- December 2013

This work was undertaken by the
Strathclyde Institute of Pharmacy and Biomedical Sciences,
University of Strathclyde, in collaboration with the NHS Highland and Clyde, Macmillan Rural
Palliative Care Pharmacist Practitioner Project Team

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All participants of the interviews and questionnaires
1 Introduction

The University of Strathclyde is funded to provide academic input into the NHS Highland project for 2 years (starting February 2013). The project is to be a demonstration project to inform national policy and will have direct relevance to the new proposal on the delivery of pharmacy services within NHS Scotland, ‘Prescription for Excellence’ (1). This opportunity gives NHS Highland access to the expertise developed through the previous Glasgow program (2) and allows the University team to develop the evidence base for clinical practice within this area, and focus on developing rural pharmaceutical care capacity through the use of a community pharmacy-based practitioner.

The NHS Highland project pilots the role of one full-time Macmillan Rural Palliative Care Pharmacist Practitioner (referred to as Macmillan Rural Pharmacist Practitioner or MRPP) to be located within a community pharmacy in the Skye, Kyle & Lochalsh project area and test the ability of a community based pharmacist to:

- Develop community pharmacy capacity to effectively, efficiently and safely support the needs of those in this rural community with cancer and palliative care needs regardless of care setting
- Improve service provision/co-ordination of services ensuring opportunities are developed for training and peer support
- Provide quality information to support practice.

In response to a development request from NHS Highland, Macmillan Cancer Support agreed to fund an evaluation of this new model of service provision. The Boots Company PLC were awarded the contract for service provision. It is intended that a positive evaluation would allow the model to be shared with other cancer and palliative care providers across the UK and be promoted as a model for use in rural areas. The aim of the evaluation is to inform the development and demonstrate the effectiveness of the Macmillan Rural Palliative Care Pharmacist Practitioner Project. The evaluation would also assess the impact of communication and co-ordination issues which relate to the provision of palliative pharmaceutical care to patients and carers in this rural community.

2 Methods

A single case study methodology, involving multiple healthcare settings within the project area was applied. Three methods were used to maximise data collection and incorporated semi-structured interviews with participant observation (when appropriate), completion of activity logs, service audits and questionnaires.

2.1 Method 1: Interviews, Observations & Logs

*Semi-structured Interviews & Observations*

Semi-structured face-to-face and telephone interviews were conducted with GPs, GPs from dispensing practices, dispensing staff from dispensing practices and a number of Key Service Leads (KSLs), with a focus on identifying specific medicine type issues faced by healthcare professionals in
the area, as well as potential benefits provided by their service. Researchers also observed the dispensing process (simulated in order to protect patient identity) in GP dispensing practices.

**Logs Detailing ‘Medicines-Related Issues’**
Community pharmacy staff and community nursing staff were asked to record palliative medicine issues in a log which the University provided. Examples of palliative medicine issues were given to staff in order to aide their understanding of what would be considered as relevant entries. Staff were asked to complete logs over an initial 4 week period beginning the first week of April 2013, which was extended due to the low volume of cases for a further 4 weeks. Once data collection ceased, follow-up telephone calls were made for more in-depth discussions of issues identified in the log. The telephone interviews were used to validate the logs.

### 2.2 Method 2: Highland Hospice Phone Line Audit

An audit of all calls received by the Highland Hospice Phone Line from the beginning of March until the end of June 2013 were collated and if considered to be in any way connected with palliative medicine-related issues the details were extracted from the hospice log and entered onto a summary document supplied by the University Team where they were analysed.

### 2.3 Method 3: Care Home Questionnaire

NHS Greater Glasgow & Clyde recently completed a survey of care home staff in Inverclyde. A modified version of this questionnaire was used in this study. The MRPP contacted all of the care homes (n=7) in the project area and requested their participation. The MRPP distributed paper copies of a participant information sheet and the questionnaire to six of the seven care homes (one declined to participate).

### 3 Key Findings

#### 3.1 Results 1: Interviews, Observations & Logs

**Setting The Scene- Environmental, Infrastructureal & Current Pharmacy Service Factors**

Participants commeted extensively on certain environmental and infrastructural factors, such as poor weather and problematic road conditions, as well as on the current level of pharmacy service in the area which contributed greatly towards setting the scene. Participants also identified and commented on relationships with other key players in the service provision in the form of members of both local (i.e. the project area) or national (i.e. Scotland-wide) networks.

Table 1 provides a summary of the other key categories and sub-categories found in the interview, observational and log data.
### Table 1 - Categories & Sub-Categories with illustrative quotes from Interviews, Observations and Logs

<table>
<thead>
<tr>
<th>Categories/Sub-Categories</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Strengths of the Service</strong></td>
<td></td>
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<tr>
<td>Healthcare Professional Planning</td>
<td>“When the doctors are prescribing we tend to ring [the pharmacy] to see what they’ve got in…So we tend to check what they’ve got in first, so that we know that we can get it, ‘cause sometimes it can take a few days.” (KSL3)</td>
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<tr>
<td>Equipment &amp; Medicines</td>
<td>“I think we’ve only ever had one episode where we’ve had two people on syringe drivers and the community will loan us one of theirs if they’re not in use.” (KSL3)</td>
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<tr>
<td>Continuity of Care</td>
<td>“The big strength is that we’re still a community…you’re looked after by the same nurses when you’re ill getting chemo or when you’re terminally ill.” (KSL6)</td>
</tr>
<tr>
<td><strong>Current Gaps in the Service</strong></td>
<td></td>
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<tr>
<td>Healthcare Professional Education</td>
<td>“I think generally the difficulty in recognising what is palliative care is the single biggest challenge, because we know that GPs struggle with it because they don’t recognise when to put people on the palliative care register, what does being palliative care mean?” (KSL7)</td>
</tr>
<tr>
<td>Patient Education</td>
<td>“[Patients] need to be educated in what [opiates] are and how to use them… I have to spend time talking to people about morphine and the fact that it’s not a dangerous thing and it should be used carefully and people should use enough of it and that all takes time.” (KSL6)</td>
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<td><strong>Suggestions for MRPP role</strong></td>
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<tr>
<td>Provide advice for health professionals</td>
<td>“[The MRPP’s] got the knowledge for anything to do with palliative drugs…we could phone her directly and let her sort it out and she would probably, hopefully have the time to be able to focus on it…so think that’s going to be a huge bonus.” (KSL1)</td>
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<tr>
<td>Influence/monitor the management of medicines.</td>
<td>“[The MRPP] could have quite a lot of input in the patients’ sort of medication....[one] care home has quite unskilled workers with the patients and their understanding of medication isn’t fantastic.” (Pharmacist)</td>
</tr>
<tr>
<td>Provide general pharmacy presence in community hospitals, care homes and dispensing practices</td>
<td>“The first thing is actually having somebody physically here who will come in and talk and will think about pharmacy issues...having somebody who is purely focusing on the medication issues is bound to be a source of support and help and improve standards, improve education, improve dissemination of practice from the centre.” (KSL6)</td>
</tr>
<tr>
<td>Link healthcare professionals and organisations/resources</td>
<td>“I think the new role here for the pharmacy here will [link] with some of our charity organisations such as Skye Cancer Care and you know sort of looking at how that charity could perhaps be influential in supporting local initiatives.” (KSL7)</td>
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<tr>
<td>Facilitate/provide training opportunities for staff.</td>
<td>“I think it’s about just ensuring that there is on-going training of all of our staff, that people are up to speed in all the latest developments around palliative care and palliative medicine.” (KSL7)</td>
</tr>
<tr>
<td>Provide advice for patients, and link patients with healthcare professionals</td>
<td>“Dealing with the patients, dealing with the other health professionals around them and sort of being a centre.” (KSL8)</td>
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</tbody>
</table>
3.2 Results 2: Highland Hospice Phone Line Audit

Ultimately, 11 telephone enquiries were logged during the eight weeks sampled. The calls came from Portree (n=5), Kyle (n=3) and Dunvegan (n=2), with one caller not specifying their location. Table 3 presents an overview of the Highland Hospice Calls.

Interestingly, the majority of calls (72.7%) were made by GPs and were made during working hours (63.6%). The Hospice Phone Line was used as a source of support as well as a source of advice for healthcare professionals and patients looking for further guidance.

3.3 Results 3: Care Home Questionnaire

Four care homes (67%) returned 21 questionnaires. Due to the small number of questionnaires returned, detailed analysis was not possible and hence summary descriptive statistics have been reported.

The data implies that the patient’s GPs and NHS 24 are the most popular choices for staff when needing information about medicines, both during and out of working hours. The Community Pharmacist is not considered as a source of advice. In addition, the Specialist Palliative Care Pharmacist was also not cited as a source of support.

Technology appears to be is poorly utilised perhaps due to unreliable connections in the area. Staff appear to prefer face-to-face contact with pharmacy staff when explaining the urgency of palliative prescriptions. Informal discussions with the MRPP reveal that most situations are dealt with face-to-face. A desire for better communication is evident. A potential role for the MRPP may be to help reinforce relationships between personnel in the care homes and other staff across the project area.

Participants did not consult the written palliative care resources mentioned. This suggests that these documents were not perceived as relevant for their job role. This coupled with the expressed need for more training suggests care home staff do not feel they are aware of all of the resources or guidelines needed in palliative care. Another factor is that due to the perceived small numbers of palliative patients, there may be times when care homes will possibly not have any residents with palliative needs, and therefore staff can become de-skilled. It is reassuring that some care home staff are currently undergoing palliative care training in order to address these needs.

4 Conclusions

This report is the first output from the evaluation program and focuses on the investigation to characterise the provision of community pharmacy services within the project area, identifying not only service gaps but identifying key issues which can be used to inform a quality improvement program.
In particular, this report can be used to support an action plan to enhance the current service provision, by supporting the wider healthcare team and provide a focus for the evolving role of the MRPP. Since a wide range of healthcare professionals were consulted the findings are a relatively comprehensive mapping of current service provision.

4.1 Current Strengths & Good Practice

- The community within the project area is relatively stable, with little fluctuations in demographics out-with the tourist season. This means that demand for palliative services including medicines can be more predictable than other areas with a higher population turnover
- Healthcare professionals accept the environmental challenges posed by the project area and are able to effectively deal with these
- There is a strong sense of community, whereby healthcare professionals go above and beyond to ensure patients receive the appropriate care
- The current palliative care service is responsive to individual patient needs, both within and out-with working hours
- Access to core medicines for palliative care is relatively easy and generally reliable
- The Highland Hospice Phone Line is available to patients, carers and other healthcare professionals as a source of advice and support 24/7, but is primarily used by GPs.

4.2 Current Challenges

While issues such as weather, geography and population density cannot be controlled, their potential adverse effects can be addressed by resource planning and education / training. On the whole, little if any problematic issues were identified but greater use of formalised contingency planning would be helpful. Additionally, increasing the education provision throughout the MDT would improve the knowledge base, acting against a lack of experience due to lack of patients requiring palliative care. While professionals going ‘above and beyond’ is admirable and inevitable to an extent, effective forward planning must aim to reduce this to an acceptable minimum.

A number of challenges were identified throughout the course of the first year of the project and can be categorised as follows:

**Education & Training**

- A lack of recognition amongst practitioners that palliative care applies to all progressive incurable diseases which no longer respond to active treatment. Consequently the term ‘palliative’ potentially applies to a larger population than currently defined
- Care home staff generally lack awareness of the population of palliative patients in their care homes, and suffer a lack of confidence in their abilities to recognise, support and address patients’ needs

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1 This characteristic was established through informal discussions with the Steering group.
• Dispensing staff within dispensing practices are not compelled to undertake any formal medicines training. Training is made available NHS Highland Health Board funding but there appears to be variable access and uptake. The benefits of undertaking specific training may need to be more acutely demonstrated to dispensing staff

• Knowledge of more specialist palliative medicines such as specials, particular formulations and controlled drugs is rather limited, largely because of the perceived low number of palliative care patients treated at any one time.

**Integration of the Pharmacist into the MDT**

• There is a lack of understanding amongst the wider MDT of the knowledge, skills and expertise of the Community Pharmacist and the Area Specialist Palliative Care Pharmacist. This often results in an over-reliance on the GP when it comes to advice about palliative care medicines

• The pharmacist should be considered a key resource not only for advice concerning palliative medicine but should also be integral in care planning such as Gold Standard Review meetings

• The community hospitals currently lack access to pharmaceutical input including support with medicines management plus clinical pharmacy advice

• Patients generally lack understanding around the safe and appropriate use of opioids and potentially other medicines. The Community Pharmacist is ideally placed to address this.

**Forward Planning**

• Many healthcare professionals go above and beyond to deliver care. Although this reflects the healthcare professionals’ dedication to providing excellent care, it shows that there may not be sufficient plans or procedures in place to deal with particular situations

• There is large expectation on the GP as source of advice, support and as a care provider. This often results in the inappropriate use of the GPs’ time, both within and outwith normal working hours

• There need to be suitable mechanisms in place to provide awareness amongst the MDT of current pharmaceutical practice appropriate to their settings.
Figure 1: Activities Currently in Place and Areas for Further Work

FORWARD PLANNING

INTEGRATION OF THE PHARMACIST INTO THE MULTIDISCIPLINARY TEAM (MDT)
- MRPP attendance at GSF meetings
- Patient Support on the Safe Use of Opioids
- Patient Literacy & Medicines Information
- Community Pharmacy-Based Prescribing Clinics
- Community Pharmacy Drop-In Clinic
- Controlled Drugs Audit
- Healthcare Professional Training Support

EDUCATION & TRAINING
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