Faculty of Cancer Pharmacy and the British Oncology Pharmacy Association

GUIDANCE FOR THE DEVELOPMENT OF PHARMACIST NON MEDICAL PRESCRIBING AND REVIEW OF PATIENTS RECEIVING ANTICANCER MEDICINES

Guidance For The Development Of Pharmacist Non Medical Prescribing And Review Of Patients Receiving Anticancer Medicines

Document Control

Title	Guidance for Non Medical Review and Prescribing of Anticancer Medicines and supportive therapies for Oncology and Haematology Patients
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Contributor	**Section/Contribution**
Calum Polwart	General comments, framework document
NECN Chemo Group	General comments, models of care
Dr Graham Dark Consultant Medical Oncologist, NCCC	Competencies and medical advice
Bruce Burnett, Helen Flint , Ann Hines and Tim Root	General comments, grammar and clarification of detail.
SCAN (via Ewan Morrison), POP via Julie Mycroft, BOPA membership, Sue Marsh	General comments, clarification and additional detail.

Information Reader Box

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1 Executive Summary

Pharmacists and nurses can undertake training to become Non Medical Prescribers, NMP's. Oncology and Cancer Services pharmacists have many opportunities to work alongside consultant oncologists (Medical and Clinical) and consultant haematologists in the prescribing of chemotherapy and supportive treatments for cancer therapy. The Faculty of Cancer Pharmacy (FCP) and British Oncology Pharmacy Association (BOPA) welcomes the development of pharmacists and nurses as non-medical prescribers (NMPs) working in cancer services.

Chemotherapy nurses, specialist nurses and oncology pharmacists regularly undertake mid cycle reviews of patients receiving anticancer medicines when the patient does not require medical review. This has increased the flexibility of chemotherapy services and has helped manage workload. Pharmacists who review cancer patients for their suitability to continue with planned anticancer medicines should meet the level one competencies detailed in this document.

The purpose of this document is to give guidance for Trusts wishing to develop the roles of oncology and haematology (Cancer Services) pharmacist NMPs – both independent prescribers and supplementary prescribers. The document does this in two ways:

- Provides a framework for the development of NMP roles within cancer services. Examples of the types of roles which can be developed are discussed.

- Provides competencies that detail the knowledge and skills the pharmacist working as a NMP must have and describes the relationship they will have with their supervising consultant. The competencies have been taken from the Medical Oncology Curriculum which is approved by the Royal College of Physicians and the Postgraduate Medical Education and Training Board, PMETB. We believe it is important that NMPs are able to work to the same standards as medical prescribers and therefore achieve and maintain these competencies in addition to those undertaken in the prescribing qualification. The competencies are the first two levels of the five levels that doctors must achieve in Medical Oncology training.

It is anticipated that pharmacists who have obtained the NMP qualification, have status as independent prescribers and have demonstrated that they have suitable competencies in cancer services should be able to work alongside consultants. Their role will include reviewing patients having chemotherapy and prescribing chemotherapy, following initial treatment plan/ prescribing decision from their medical colleague. There is also a role for prescribing supportive medicines, supporting staff in associated wards, clinics and day case units and for using the prescribing qualification at ward level for amending, updating and initiating prescriptions. This is a natural extension of the oncology pharmacist role. This will benefit medical prescribers by easing some of the burden of routine prescribing/ patient care and ensuring services are responsive to patient's needs. NMPs are not medically trained and are not seeking to replace the role of the doctor.

2 Definitions / Limitations

It is recognised that the role of NMPs in cancer services will grow as pharmacists working in these areas gain experience and credibility and seek to expand their roles over time. It is also recognised that the NMPs role in cancer services will be different in different Trusts. This document does not provide a limit on future role developments provided they are within a locally approved framework, subject to local peer review and are consistent with national guidelines.

For the purposes of this document the term anticancer medicine is used to refer to all drugs with direct anti-tumour activity, administered to cancer patients, including traditional cytotoxic chemotherapy such as carboplatin, capecitabine, hydroxycarbamide, paclitaxel and newer targeted therapies such as imatinib, sunitinib, rituximab and other agents such as thalidomide. It does *not* include hormonal or anti-hormonal agents such as tamoxifen and anastrazole.

3 Background

In April 2006 the Department of Health (DH) allowed nurses and pharmacists to become independent prescribers and encouraged the NHS to develop these roles. (DH 2006). The DH guidance states that NMPs can improve patient care without compromising patient safety by making it easier for patients to get the medicines they need and allowing more flexible team working across the NHS.

The DH's working definition of independent prescribing is prescribing by an 'appropriate practitioner' (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required.

4 Pharmacist Role(s)

This document covers pharmacists. Nurses can also become NMPs and the principles in this document can easily apply to nursing, however it is beyond the remit of BOPA/FCP to set guidance for nursing staff. Pharmacists and nurses have differing skills but both have a complementary role in non-medical prescribing for cancer patients. Each profession can learn from each other when becoming NMPs working with cancer patients and it is suggested that local Cancer Networks should form a local support network for local NMPs and share learning and best practice.

Having an cancer service pharmacist initiating a prescription does not eliminate the requirement for a (second) pharmacist's role in checking and validating the prescription. NMPs **must not** be directly involved in checking/ dispensing of prescriptions they have written. The Royal Pharmaceutical Society of Great Britain (RPSGB) state that NMPs must 'ensure separation of prescribing and dispensing whenever possible. Where a pharmacist is both prescribing and dispensing a patient's medication, a second suitably competent person should normally be involved in the checking process.'

It is also recognised that other professions can become NMPs. Radiographers can become supplementary prescribers and there may be a role for radiographers to prescribe supportive medicines for cancer patients undergoing radiotherapy.

5 Accountability

All non medical prescribers are personally accountable for their practice and must work to the same standards and competence that applies to medical prescribers. This includes the requirement to use pre printed prescription pro forma's/ e-prescribing systems and compliance with Cancer Network approved regimens etc. As prescribers, health care professionals have a duty to their employers to use resources efficiently and effectively. Therefore the number and cost of items prescribed must be monitored and local formularies must be taken into account where they exist.

Pharmacist prescribers are individually professionally accountable to the Royal Pharmaceutical Society of Great Britain (RPSGB) and must act at all times in accordance with the RPSGB Code of Ethics and Standards and follow the Society's guidance on non medical prescribing.

In order to exercise accountability and duty of care, all NMPs must identify and meet their individual continuing professional development (CPD) needs via, for example, additional training, clinical supervision, clinical placements, reading and research.

6 Workforce and Service Development

It is noted that there will be workforce issues around the development of NMP roles in Trusts, but that these should be dealt with at a local Trust level. When developing the role of the NMP the key questions for the Trust to address are:

- The need for the pharmacist to work as a NMP with cancer patients
- The advantages to the Trust of having a pharmacist working as a NMP with cancer patients
- The impact of establishing pharmacist NMPs on existing pharmacist clinical roles. Note it may be that the role is an extension of current activity and may not have a major resource implication
- The arrangements for 'backfill' of the pharmacists duties where necessary.

As NMP roles are relatively new it may be the case that pharmacists train as NMP's then develop their role as they gain experience and recognise opportunities.

7 Models of Care: Oncology/ Haematology Clinics

An understanding of the medical model of seeing and reviewing patients undergoing chemotherapy and systemic anticancer therapy is necessary to see where NMPs 'fit in.' This document will also give a description of the cancer patient pathway highlighting where pharmacists can be involved and also set out the standards for their involvement. It must be noted that this is not exhaustive and local services may develop different but equally valid models of care than those described below.

Cancer patients receiving anticancer medicines for solid tumours are generally under the care of consultant medical or clinical oncologist. The model encouraged by National Chemotherapy Advisory Group (NCAG) and the Peer Review process is for common cancers to be treated in local Cancer Units Trusts or level one and level two services. These include breast, colorectal, lung, and can included some upper GI, some urology including renal, prostate and gynaecological cancers depending on local arrangements. The key factor is that all the treatments can be safely given as day case in oncology out patient wards within the Trust. Rarer cancers and those regimens requiring prolonged inpatient stay are usually treated in the cancer centres. Haematological malignancies are managed in a similar way with Trust haematology services divided into different service levels, with outpatient chemotherapy in level 1/2 services and complex inpatient chemotherapy treated at level 3/4 centres.

The majority of cancer treatment follows a clinical model based upon initial review at a Multidisciplinary Team Meeting (MDT), where the patient's case is discussed. The MDT usually consists of pathologists, surgeons, physicians, oncologists, nurse specialists and physiotherapists etc as appropriate. Pharmacists do not routinely participate in weekly MDT meetings, however as NMPs their attendance would be valuable. At the MDT the patient's treatment plan will be decided. Typically if this is a common cancer such as breast or colorectal the patient will be having surgery and/or radiotherapy and then at some point be deemed suitable for anticancer medicines. Once it has been determined that chemotherapy or systemic anticancer medicines are the preferred treatment option they are then referred to a consultant oncologist. The oncologist will see the patients in an out-patient clinic. At the initial appointment they will discuss the patient's diagnosis and the potential treatment plan with chemotherapy /anticancer medicines.

For advanced cancers this will generally involve palliative chemotherapy to extend patients life/ manage symptoms. One of the largest uses of anticancer medicines in common cancers is for adjuvant chemotherapy treatment. That is where chemotherapy is used following surgery or radiotherapy to reduce the risk of the cancer returning and provides systemic treatment to ensure that all cancer cells have been removed from the body.

8 Framework for NMPs

It is recognised that NMPs do not have a medical qualification and therefore there ideally needs to be a framework that describes exactly what responsibilities they have during their clinical practice. It is also recognised that this framework may differ for different types of cancer e.g. adjuvant breast cancer patients present different challenges to lung cancer patients. A framework should be produced prior to clinics being set up; an example of the template for framework is attached (appendix 1). The framework will define what the NMP will and will not do and also give criteria about referring back to the medical consultant. The framework can be used as the basis of the business case for developing the role if needed and should be discussed an appropriate local Trust Clinical / Governance group(s, e.g. Chemotherapy Group, Drug and Therapeutics Committee or Medicines Management Group. Note it is recognised that there are many established pharmacist NMPs who have already developed services without a framework. In this case we suggest it would be good practice to develop a framework retrospectively to support the role of the NMP

It is important that NMPs have a medical prescriber as their clinical champion, in developing a framework the NMP should involve and seek the views of the doctor(s) and MDT they will be working alongside.

Looking at the model for how pharmacists work alongside their medical colleagues, the consultant and NMP will agree the appropriate patients to be managed by the NMP and *ideally* the patients will be seen in a clinic running alongside the existing consultant clinic. For example, this could include the majority of adjuvant patients for breast cancer and include some treatments in advanced disease.

The structure of oncology/haematology clinics will vary dependent on the skills of the professionals performing the clinics and local service requirements. NMPs may manage their own caseload as there may not always be a consultant present in clinic/ward to work alongside the NMP. A medical consultant, ideally the patient's consultant, must always be available to the NMP for medical advice when NMPs are seeing patients, i.e. physically or by telephone and the mechanism for this documented in the framework.

Prescribing supportive care on an oncology day ward or prescribing on in-patient wards can be done on a more routine day to day basis without supervision of a consultant provided there is an agreed framework that covers the NMPs role.

It is recognised that being a prescriber carries a professional responsibility, that the pharmacist will use their judgement when confronted with patients and should a patient present a clinical challenge or symptoms and signs of which the pharmacist is unsure, they would then seek advice from their medical colleague. That is why the *ideal* model is pharmacist and consultant working in adjacent or nearly adjacent consulting rooms to facilitate this cross checking and support. This model is similar to consultants working in this way with their registrars and trainees. If the NMP is not working alongside the consultant, there must be a pathway in the framework for sending patients for urgent medical review.

A key feature of the competencies is the ability for the NMP to recognise the limits of their ability. NMPs are not medically qualified and are not seeking to replace/ take over doctors roles, but to work as part of a specialist team delivering care to oncology/haematology patients.

8.1 Supplementary (SP) vs. Independent Prescribers (IP)

All chemotherapy prescribing in cancer services is driven by written protocols which NMPs would be expected to follow. In addition this will often apply to supportive medications, e.g. antiemetics. NMPs in cancer services can be supplementary prescribers working in accordance with clinical management plans. The clinical management plans should be based upon these protocols/regimens. The requirement to work as either a SP or an IP should be part of the local framework.

The framework should clearly specify and differentiate between the respective roles of SPs and IPs. SPs have a responsibility to produce clinical management plans for named individual patients in conjunction with their medical mentor.

9 What can NMPs prescribe?

Once qualified an NMP IP can prescribe any licensed medicine (i.e. any product with a UK marketing authorisation) for any medical condition (apart from controlled drugs for pharmacists) provided it falls within their area of competence. Supplementary prescribers can provide any medicine that has been included in an agreed clinical management plan. NMPs are advised to ensure that their practice complies with local policies for use of unlicensed medicines and controlled drugs.

9.1 Prescribing First Cycle of Anticancer Medicines

One constraint on the role of the NMP within cancer is the requirement within the National Cancer Quality Measures (for England) that the first cycle of any chemotherapy be prescribed by a Consultant Oncologist or Haematologist. This is different from all other medical specialities where NMPs can initiate any therapy apart from controlled drugs and must be seen as part of ensuring patient safety.

The FCP/ BOPA recognises that there may well be now and in future NMPs who are competent and able under an agreed service model to see new patients following treatment decision/ plan at MDT and prescribe chemotherapy from the first cycle onwards. However it is not recommended this is undertaken and that the Cancer Quality Measures are applied and that the first cycle of chemotherapy is prescribed by a consultant oncologist or haematologist until such time as the measures change.

9.2 Range of systemic anticancer therapy prescribed by NMPs

By its nature adjuvant chemotherapy can require less intense monitoring of disease progression than advanced treatment with a palliative intent. It is anticipated that NMPs may have an initial role in the review of patients where it has been decided to prescribe adjuvant chemotherapy. However, depending on the experience of the NMP it is also likely that they could undertake management of patients diagnosed with advanced cancers.

It is anticipated that the greatest demand will be for NMPs to support prescribing for patients with common cancers receiving adjuvant / first line treatments. Note: whilst it can be debated that adjuvant treatment is more straightforward than treatment for advanced disease it must be acknowledged that there are long term risks associated with adjuvant treatment. Individual patient factors and regimen toxicity profiles can dictate how 'complex' a patient group is to manage. There will also be pharmacists specialising in less common cancers, e.g. paediatric oncology who will have a different approach to NMP practice

Some oncology pharmacists will have significant experience of a particular patient group and may therefore wish to initially restrict their prescribing to this area. NMPs may prescribe for more that one tumour site depending on their knowledge and skills relating to these tumour groups, however their prescribing will be in line with approved care pathways. Pharmacist NMPs should consider the medical model where consultant oncologists will site specialise to a small number of cancer sites and generally restrict their prescribing to those patient groups.

It is recommended that when NMPs who are not specialist in one particular clinical area start prescribing they gain experience with adjuvant patients before prescribing for advanced disease

9.3 Examples of areas of NMP roles in cancer services

- Intravenous anticancer medicines as part of review and authorisation of treatment from 2nd and subsequent cycles (see comments above)
- Herceptin (trastuzumab) for early breast cancer, NMPs can take responsibility for managing the prescribing for these patient's reviewing their echocardiograms and blood results every three months and authorising ongoing prescriptions.
- Oral anticancer medicines, e.g. capecitabine. Pharmacists and nurses are increasingly involved in the review of these medicines and assessing suitability for continuation with therapy.
- Long term medication for haematology patients, e.g. prescribing hydroxycarbamide for patients with essential thrombocythaemia or polycythaemia. For example the

patients could have a full blood count (FBC) at their local general practitioner before visiting the hospital where the NMP would review the results, make any necessary dosage changes and issue prescriptions for the ongoing hydroxycarbamide This may be an attractive alternative to a shared care arrangement as the NMP will work closely with the consultant haematologist easing the 'routine' workload for these patients but be onsite and at hand to refer/ discuss management as appropriate.

- Supportive Care

  As well as the model of pharmacists working alongside consultants in clinic it is recognised that there is a prescribing role on oncology units and on oncology wards in the centre. In the centres this may well include a prescribing role for in-patients and in cancer units it is likely to include prescribing supportive care items that are not available under patient group directions (PGDs) for example varying courses of antiemetics and other medications that cancer patients need to treat the side effects of the chemotherapy treatment, or their underlying disease. Non medical prescribers undertaking this role and prescribing for patients should have agreement from the consultant(s)/clinical teams whose patients they are prescribing for. Using NMP's to prescribe supportive care results in much greater flexibility than using PGDs.

10 Competencies for Pharmacists Working as Non Medical Prescribers in Cancer Services

As part of achieving the prescribing qualification NMPs have to demonstrate competency in a wide variety of areas e.g.

- Clinical and pharmaceutical Knowledge
- Communicating with patients
- Consultation skills
- Clinical examination skills
- Safe prescribing
- Prescribing in context/ professionalism

NMPs either operate as independent prescribers (IP), within their own area of expertise or as supplementary prescribers (SP) working under an agreed clinical management plan for individual patients within their own area of expertise.

10.1 Competency framework

This competency framework for NMPs has been directly adapted from the framework used in the Medical Oncology Training Programme.

The medical oncology framework has five levels; level 1 and 2 have been included in these guidelines as they are directly relevant to NMPs. Levels 3 and above differentiate the responsibilities of medically qualified prescribers from NMPs in Oncology / Haematology. However some competencies from level 3 have been added to level 2 (denoted with *) as they are deemed appropriate for NMPs. The key difference between a level 2 and a level 3 prescriber is the ability of a level 3 medical practitioner to prescribe first cycle, i.e. initiate chemotherapy/ systemic anticancer therapies. A proforma for recording competencies has been provided in appendix two.

Notes:

- It is recognised that the training programme/competencies for clinical oncology and haematology specialities will be different to that of medical oncology but for the purposes of clarity only one set of competencies has been referenced.
- The competencies around prescribing blood products have been amended as NMPs cannot prescribe blood products.

10.2. Competency Level ONE

A practitioner working to level 1 is able to undertake a review of a patient receiving systemic therapy and can authorise the next cycle of treatment to proceed. This professional could be medically qualified or an appropriately trained chemotherapy nurse, oncology pharmacist or a professional allied to medicine. If the professional competencies in oncology/haematology described below are met then NMPs will be able to operate at this level during their training period as an NMP. NMPs already qualified must be able to demonstrate they meet these competencies. In addition the level 1 competencies form the basis for good practice for nursing and pharmacists who are not NMPs but are routinely involved in nurse/pharmacist lead review of mid cycle chemotherapy between medical reviews.

Competencies

- Ability to authorise treatment to proceed following assessment of the patient and relevant laboratory investigations.
- Ability to review a prescription for systemic therapy and accurately identify errors or omissions.
- Ability to demonstrate knowledge and understanding of the methods for calculating the correct dose of medication for administration including those based on body surface area, pharmacokinetic and pharmacodynamic principles.
- Ability to define the scientific basis of causation of nausea and vomiting and ability to identify the likely mechanism of emesis in a patient receiving systemic therapy.
- Ability to determine the antiemetic requirements of patients receiving systemic therapy.
- Understanding of issues surrounding administration of intravenous therapies, e.g. principles of extravasation treatment.
- Ability to define the principles for dose delay or dose reduction of systemic therapies, based upon haematological toxicity.

10.3 Competency Level 2

A practitioner working to level 2 is able to prescribe systemic therapy, within local guidelines, or to continue a planned course of treatment but not initiate the first course of treatment. This professional is likely to be medically qualified or a nurse/ pharmacist NMP.

Competencies

- Ability to define the range of systemic therapies utilised in the treatment of patients with cancer and define the likely adverse effects of the agents in more common usage within a clinical service.
- Ability to prescribe and order systemic therapies following assessment of the patient and relevant laboratory investigations, using appropriate systems defined by the local authorities.

- Ability to accurately prescribe systemic therapies using various methods for calculating the correct dose of medication for administration including those based on body surface area, pharmacokinetic and pharmacodynamic principles.
- Ability to define the scientific basis and parameters for dose modifications to systemic therapy in the light of clinical data relating to the liver, renal, haematological and other organ systems.
- Ability to institute appropriate modifications in the prescription of systemic therapy in the light of clinical data that will relate to dose modification parameters relating to organ function.
- Ability to perform a thorough assessment of toxicity and record the clinical information using defined systems such as the Common Toxicity Criteria.
- Ability to prescribe antiemetic medications appropriate to the chosen therapy and ability to modify following review of the patient's situation and symptoms following previous treatments.
- Ability to define and initiate appropriately the pharmacological and non-pharmacological supportive measures that may be required by patients receiving systemic therapy, including growth factors and antibiotics.
- Ability to demonstrate knowledge and understanding of the indications for and adverse reactions associated with the use of blood products.
- Ability to obtain informed consent for procedures and initiation of treatments.
- Ability to request assistance and advice when a situation requires the involvement of a more senior colleague.
- Ability to determine the appropriateness of continuing treatment, particularly in patients with poor performance status or significant co-morbid conditions.
- Ability to assess objective tumour responses and toxicity and make a balanced judgement about continuing.
- Ability to modify the dosage of systemic therapy based on pharmacokinetic and pharmacodynamic information relating to a patient.*
- Ability to define the scientific mechanism of action of the systemic therapies used in the management of cancer patients*.
- Appropriate recognition of level of competency reached.

10.4 Pharmacist Specific Competencies

It is recognised that oncology pharmacists may well have a different degree of experience and training. An oncology pharmacist is traditionally a title that is given to a job rather than by a route of accreditation and/or demonstration of educational competency. BOPA set up the Faculty of Cancer Pharmacy FCP with the College of Pharmacy Practice in 2008 to provide an accreditation route. The FCP provides an accreditation route for oncology pharmacists based on review of a portfolio of evidence from practice. There is also the higher education route through which pharmacists are able to study and achieve postgraduate qualifications in oncology.

BOPA/ FCP suggest any pharmacist who is working as a NMP in cancer services and prescribing systemic anticancer therapies should be working at Agenda for Change Band 7 or above and meet the following requirements and competencies:

1 *Ideally* has:

- Either a post graduate qualification in oncology at minimum of Diploma level. This could be an MSc or a Post Graduate Diploma in Oncology.

- Or has achieved membership of the Faculty of Cancer Pharmacy by submitting a portfolio of evidence of their practice. This will have been peer reviewed and they will subsequently be accredited as an Advanced Level Practitioner in Oncology Pharmacy by the Faculty Board. If practice is restricted to prescribing supportive medicines as an SP it may only be necessary to be accredited at General Level. We suggest that all pharmacists working as prescribers in oncology should work towards having a portfolio submitted to the FCP and demonstrate their competence and continuing professional education in this area by ongoing membership of the Faculty. It is recognised that the profession of pharmacy is undergoing big changes with the formation of the general pharmaceutical counsel and the new professional body. The College of Pharmacy Practice is a key stakeholder in the new professional body and seeks to embed itself in this organisation and keep the accreditation for oncology pharmacists on the agenda in the new professional body. However, we recognise that there is a lot of uncertainty regarding the future roles and responsibilities of the new professional body and whether one of them will be accreditation of specialist practice

2 It is recognised that there may be pharmacists who have undertaken the prescribing qualification who do not have a post graduate qualification in oncology and currently are not members of the Faculty of Cancer Pharmacy. It is suggested that these pharmacists should, if they are already working as NMPs, have demonstrated competency through their prescribing course and be signed off by the consultant who was their mentor during the prescribing training. They should demonstrate continuing competency as an oncology pharmacist by undertaking an assessment of their practice against the BOPA Competency Framework for Oncology Pharmacy and / or the Advanced and Consultant Level Framework (ACLF). Ideally this assessment should be peer reviewed. It is expected that they should demonstrate competency to at least the 'Excellence' level and undertake a commitment to submit a portfolio of evidence to the FCP.

NMPs are required to show a commitment to CPD /maintaining their competencies.

11 Conclusions

It is recognised that this document is not exhaustive but covers the general principles that NMPs should meet the same competencies for prescribing anticancer medicines that SPRs being trained are expected to meet and that best practice is for a framework document describing the scope of practice of the NMP to be prepared.

12 References

Improving patients' access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England. Department of Health 12 April 2006

British Oncology Pharmacy Association (BOPA): Competency Framework for Specialist oncology Pharmacists: December 2004 Last accessed 4/3/09, available at: http://www.bopawebsite.org/tiki-page.php?pageName=Position+Statements

Royal College of Physicians and Association of Cancer Physicians: Training Programme in Medical Oncology. Available on request from Royal College of Physicians, 11 St Andrews Place, Regent's Park, London NW1 4LE

Appendix One

Framework Template for Chemotherapy Non-Medical Prescriber Clinics

Contents

Background

"◄Describe the background to the clinic ►" .

Resources

"◄Describe the resources in place to run the clinic. Rooms, Staffing, etc ►"

Timescales

"◄Stipulate if the clinic is time limitted ►"

Clinical Group

"◄List inclusion / exclusion crietria for patients to be seen in clinic ►"

Training & Competence

"◄Describe necessary competences - refer to framework ►"

Consider

- Patient assessment
- Hollistic care
- Prevention & Management of Side Effects

- Chemotherapy Administration Techniques
- Supplementary Prescribing

Patient Pathway & Responsibilities

"◄Describe the patient pathway inc anything to be done at each visit. Describe who will have responsibility for what. ► "

Prescribing of Chemotherapy

"◄Describe who will prescribe ►"

Prescribing of Supportive Drugs

"◄Describe who will prescribe ►"

Communication

DisplayText cannot span more than one line!

Clinical Management Plan (CMP)

"◄If supplementary prescribing is taking place: ►"

This document, combined with the treatment plan for the patient (which exists for all chemotherapy patients and is included in the oncology notes) will act as a clinical management plan.

Shared Notes to be used:
"◄Specify ►"

Reporting of adverse reactions:
Toxicity scores will be recorded in the shared notes. Patients with non-haematological CTC Grade 4, will be notified to the consultant oncologist within 24 hours (and normally on the same day). Grade 4 reactions, will also normally be reported to the CSM on a yellow card.

Patients with other Grade 1-3 CTC will be managed according to the chemotherapy protocol and documented in the medical notes. Grade 1-3 reactions will be also reported to the CSM for ▼ medications.

Drugs to be prescribed under the CMP:
The chemotherapy regimen to be followed will be specified in the Oncology Management Plan. If lower doses than normal are to be used this will be specified in the plan/on the first cycle prescription. In addition to the chemotherapy, and any other drugs listed in the chemotherapy protocol the following drugs may be prescribed under the CMP unless specified otherwise or there is a contra-indication:

Prescribing of supportive medication will be undertaken using an independent prescribing framework following local, national or international guidelines. The supplementary prescriber prescribing will be responsible for ensuring the clinical appropriateness of the medication prescribed, dose and ensuring they are confident of the diagnosis being treated. Where there is doubt over diagnosis or the appropriateness of the treatment to initiate this will be discussed with the consultant oncologist.

Frequency of Review:
Defined elsewhere in this clinic outline.

Medical Intervention

"◄Describe how medical advice including direct admission can be arrange if necessary►"
"◄Describe any specific circumstances where patients may require referral"

Examples may include:

- Patient been admitted to hospital since their last cycle of chemotherapy (for any reason)
- Patient request to be seen by a doctor
- Patient is acutely unwell
- Non-haematological common toxicity criteria of 2 or higher.
- Recurring Non-Haematological Common Toxicity Criteria of 1 or more which is not resolving despite suggested actions in the chemotherapy protocol (or where there are no suggested actions)
- Evidence of active infection
- Changing performance status (worsening)

Support & Referral

"◄Describe how medical advice including direct admission can be arrange if necessary►"

Audit & Review of Clinic Outcomes

"◄Describe arrangements for audit of clincis where appropriate ►"

Agreed By:

Oncologist / Haematologist
Date:

Trust Chemotherapy Group
Date:

Appendix Two: Record of Oncology/Haematology Competencies

Name_____**Job Title**_____

Competency level 1 (Review and Authorise Administration of Systemic Anticancer therapy)	Supporting Statement / List of Evidence	Date Achieved	NMPs Signature
Ability to authorise treatment to proceed following assessment of the patient and relevant laboratory investigations.			
Ability to review a prescription for systemic therapy and accurately identify errors or omissions.			
Demonstrate knowledge and understanding of the methods for calculating the correct dose of medication for administration including those based on BSA, pharmacokinetic/ pharmacodynamic principles.			
Ability to define the scientific basis of causation of nausea and vomiting and ability to identify the likely mechanism of emesis in patient receiving systemic therapy.			
Ability to determine the antiemetic requirements of patients receiving systemic therapy.			
Ability to administer intravenous bolus therapies, as prescribed, and according to departmental guidelines. (Nurse only)			
Ability to define the principles for dose delay or dose reduction of systemic therapies, based upon haematological toxicity.			

NMP Signature: …… Date: ……

Approved by :
(Oncologist / Haematologist)…….. Date: ……

Name_____**Job Title**_____

Competency level 2 (Prescribe Systemic Anticancer therapy - 2nd cycle onwards)	**Supporting Statement / List of Evidence**	**Date Achieved**	**NMPs Signature**
To define the range of systemic therapies utilised in the treatment of patients with cancer and define the likely adverse effects of the agents in more common usage within a clinical service.			
Ability to prescribe and order systemic therapies following assessment of the patient and relevant laboratory investigations, using appropriate systems defined by the local authorities.			
Ability to accurately prescribe systemic therapies using various methods for calculating the correct dose of medication for administration including those based on body surface area, pharmacokinetic /pharmacodynamic principles.			
To define the scientific basis and parameters for dose modifications to systemic therapy in the light of clinical data relating to the liver, renal, haematological and other organ systems.			
Ability to institute appropriate modifications in the prescription of systemic therapy in the light of clinical data that will relate to dose modification parameters relating to organ function.			
Ability to perform a thorough assessment of toxicity and record the clinical information using defined systems such as the Common Toxicity Criteria.			
Ability to prescribe antiemetic medications appropriate to the chosen therapy and modified following review of the patients situation and symptoms following previous treatments.			

Competency level 2 (Continued)	Supporting Statement / List of Evidence	Date Achieved	NMPs Signature
Ability to define and initiate appropriately the pharmacological and non-pharmacological supportive measures that may be required by patients receiving systemic therapy, including growth factors and antibiotics.			
Ability to demonstrate knowledge and understanding of the indications for and adverse reactions associated with the use of blood products			
Ability to obtain informed consent for procedures and initiation of treatments.			
Ability to request assistance and advice when a situation requires the involvement of a more senior colleague.			
Ability to determine the appropriateness of continuing treatment, particularly in patients with poor performance status or significant co-morbid conditions.			
Ability to assess objective tumour responses and toxicity and make a balanced judgement about continuing.			
Ability to modify the dosage of systemic therapy based on pharmacokinetic and pharmacodynamic information relating to a patient.			
To define the scientific mechanism of action of the systemic therapies used in the management of cancer patients.			

NMP Signature: …… Date: ……

Approved by :
(Oncologist / Haematologist)…….. Date: ……