Evaluating anticipatory prescribing in community palliative care in Jersey: A clinical audit

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Abstract

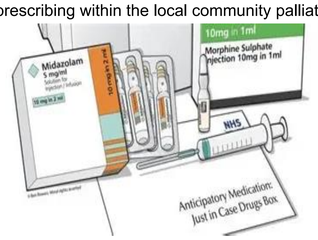
Background: Anticipatory prescribing ensures patients have access to end-of-life medications when they are required. The GOJ (2022) and NICE (2017) recommend an individualised approach to anticipatory prescribing, with a patient assessment supporting decisions on medication indication, dose and route. Pre-emptive prescribing means these medications are in place before needed, which does increase the likelihood of them not being used, and resulting in waste. Literature on this topic is underexplored.

Project design: A clinical audit was used, using a retrospective quantitative record review to examine prescribing practice within the local community palliative care setting. Purposive sampling was utilised to form the audit sample of 30 patients who met inclusion criteria. The local setting was also assessed for alignment with GOJ (2022) and NICE (2017) to determine if individualised prescribing is present.

Data collection and data analysis: All data was collected from EMIS, with quantitative data extracted through a proforma. This data explored the core medication categories, the individual medications, what was administered, what was wasted, how much did this cost, and who was the prescriber. Descriptive statistics were used for the quantitative data analysis. Qualitative narrative documentation was introduced to add clinical context to the quantitative data, adding information on patient's prognosis, the prescriber's decision making, current and expected symptoms and patients' preferences.

Findings: This project showed that most patients were prescribed all core category medicines. Individualised prescribing was demonstrated through differences in medication choice, and additional medicines prescribed for some patients. A combined total of 2,641 medications were prescribed for the audit sample, 54.6% of these were administered, meaning 45.4% were wasted. Variation in medication administration and waste was found between patient records. The qualitative narrative documentation did display evidence of individualised prescribing; however, not all prescribers narrative notes could be accessed.

Conclusion: This project has demonstrated how the local setting largely aligns with policy (GOJ, 2022) (NICE, 2017). The recommendations that have arisen from this project include continued alignment with policy, a collaborative community symptom assessment tool and a re-audit once full access to all narrative notes is obtained to ensure a comprehensive evaluation of anticipatory prescribing within the local community palliative care setting.



Introduction

Anticipatory prescribing ensures timely access to end-of-life medications, enhancing symptom control in the dying phase (GOJ, 2022) (NICE, 2017). Having these medications in place also ensures that patients can die in the place they want to, often avoiding admission to other settings for their end-of-life care (NHS England, 2021) (Marie Curie, 2022).

The symptoms that a patient experiences at the end of life will be individual to them, meaning that patients will have different medication requirements in the dying phase. The GOJ (2022) and NICE (2017) advise an individualised approach to anticipatory prescribing, where patients are assessed, with medication indication, dose and route all patient specific, dependant on individual need, reviewed as required. However, the literature reports that common practice is all patients are prescribed all core categories of these medicines to cover all anticipated symptoms, which does increase the likelihood of these medications not being used (Morgan et al., 2023) (Bowers et al., 2018).

Hospices locally and nationally are reporting financial pressures, alongside an increase in demand for palliative care services, which does suggest that a more cost-effective use of healthcare resources is needed, without affecting the quality or access to current community services (JHC, 2025) (Hospice UK, 2025b). Literature on anticipatory medication use, waste and cost is also underexplored.

Therefore, this project aims to evaluate anticipatory prescribing practice within the local setting, and assess alignment with policy, exploring if individualised prescribing is present within community palliative care in Jersey (GOJ, 2022) (NICE, 2017).

The PICOT framework was used for database searching, using databases CINAHL, Internurse and SAGE to explore current literature on anticipatory prescribing within community palliative care.

Project Question, Aim and Objectives

Question: What categories of anticipatory medications are prescribed for community-based patients in their last seven days of life and to what extent are these administered or wasted and how does this comply with NICE (2017) Quality Standard QS144 Quality Statement 3, and GOJ (2022) Adult Palliative Care: Anticipatory Prescribing Policy.

Aim: To evaluate categories of anticipatory medications prescribed for community-based end-of-life patients, and their administration or wastage, in the last seven days of life, in accordance with NICE (2017) Quality Standard QS144 Quality Statement 3; anticipatory prescribing of medications in the last week of life, and GOJ (2022) Adult Palliative Care: Anticipatory Prescribing Policy.

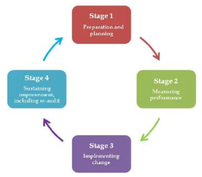
Objectives

1.To identify the categories of anticipatory medications prescribed in the last seven days of life.
2.To determine which medications were most frequently administered and what are wasted.
3.To identify if there are commonly wasted medications.
4.To estimate the cost of wasted medication.
5.To inform future anticipatory medication prescribing practice.

Project Design

Methodology:

For this project, a retrospective quantitative clinical audit was used. Using a clinical audit aligned with this project as it set out to evaluate local prescribing practice against policy. Being retrospective, data could be extracted from patients' records, being appropriate for this patient group, with the difficulty in determining when patients are in the last seven days of life. Quantitative data meant objective numerical data could be extracted and analysed. Qualitative narrative documentation introduced clinical context to the numerical data, to evaluate whether prescribing was individualised in the local setting.



Data collection Methods:

All data was collected from EMIS, using data from patients anticipatory prescribing paperwork. A data extraction proforma ensured structured and consistent data collection. A pilot was conducted, which consisted of a review of five patient records, testing its functionality before use. Data that was extracted; core category medications, all individual medications, how often were these medications administered, medication waste, and the cost of that waste. Finally, prescribing sources were reviewed. All data was inputted directly into the proforma on Microsoft Excel.

Sample:

Thirty patient records were included using purposive sampling. All patients included had died from June 2025 through to February 2026, with all meeting inclusion criteria –
-Adult patients
-Had anticipatory medications in place
-Died within the community setting
-Supported by the SPCT
Children (<18 years), patients who died in other settings and those who had AP in place for less than seven days were therefore an exclusion criteria

Data Analysis Method:

Quantitative data: Descriptive statistics were used to analyse this data. The core categories and individual medicines were explored, to determine what was prescribed, what was administered and what was wasted. The mean, median, frequencies, standard deviations and percentages were utilised to describe the findings and highlight variation between patient records. Medication costs were identified from the GOJ prescribing list, with comparison with what was remaining after the patient had died.

Qualitative data: The Hospice prescribers clinical notes were used to add context to the quantitative data, without use of recognised qualitative approach. This data review focused on prescribers' decision making; rationale, current and anticipated symptom burden, prognosis, patient's preferences for their care.

Quality Assurance and Ethical Issues:

Approval for this project was from the RGU School of health ethical review panel, also be submitted for approval with the Clinical audit team at Health and Care Jersey. Organisational approval was obtained from JHC for the purposes of using patient records for audit purposes. Patient data that was extracted from their clinical notes was stored and managed in compliance with Data Protection (Jersey) Law 2018. Once extracted, data was coded to maintain confidentiality. Due to this being a retrospective audit, patient consent and recruitment were not necessary. Ethical considerations of beneficence, non-maleficence and justice guided this project, ensuring the focus remained on service improvement and appropriate use of healthcare resources, not limiting access to anticipatory prescribing (Beauchamp and Childress, 2013).

Findings

The key findings from this project highlighted prescribing patterns locally, including what was administered, what was wasted and how much did this cost. Also exploring if the local setting prescribes using an individualised approach

1. It was shown that within the local area the core medications categories were prescribed for most patients
   - Analgesia – prescribed for 100%
   - Anti-emetic – prescribed for 100%
   - Anxiolytic – prescribed for 100%
   - Anti-secretory – prescribed for 96.7% - Patient with MND – showing patient specific prescribing
2. The findings showed variation in medication choice. Variation was shown in anti-emetic choice, with the most common anti-emetic being levomepromazine (n=18). Morphine was the most common analgesic prescribed (n=20). A small number of patients (n=5) were prescribed medications that are considered nonstandard for anticipatory prescribing; Parecoxib and Dexamethasone.
3. For the audit sample, 2,641 medication vials were prescribed. 1,442 medication vials were administered, meaning 54.6% of all prescribed were used. 776 medications vials were administered in the last seven days of life (Table1). From reviewing all patient records, administration rates varied between patients, which indicates that patients experience different symptom burdens as they approach the end of life.
4. The cost of all wasted medication was £2,812.74, with the findings illustrating that 45.4% of all medications that were prescribed did result in waste. The findings highlighted two patients who did not use any of their anticipatory prescribing. The qualitative narrative documentation shows that both remained conscious until time of death. One patient did not experience any symptoms, whilst the other used oral medications.
5. GPs were the largest prescribing source for the audit sample – 56.7%. JHC – 26.7%, and JGH – 16.6% (Table 4). Qualitative narrative documentation for the Hospice prescribers detailed discussions on patients current and anticipated symptom burden, their prognosis using GSF coding, the patients wishes and preferences for their care, and finally the rationale for medication selection. The hospice prescriber's notes did demonstrate individualised prescribing, however, due to inability to access GPs clinical notes, this could not be compared across all prescribing sources.

Medication	Vials Administered in Last 7 Days
Morphine	310
Midazolam	228
Glycopyrronium bromide	109
Levomepromazine	67
Haloperidol	33
Oxycodone	19

Table 1: Medication administered in the last seven days of life

Figure 2: Total Vials Prescribed, Administered and Wasted

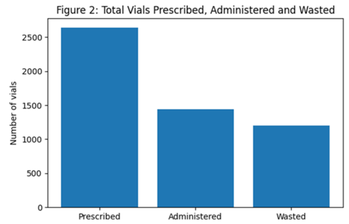
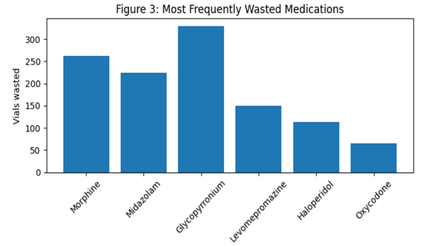


Figure 3: Most Frequently Wasted Medications



Prescriber	Patients (n)	Percentage (%)
GP	17	56.70%
JGH Doctor	8	26.70%
Hospice Doctor	5	16.60%

Table 4: Prescribing Source

Limitations

The relatively small sample size, and that data focused on a small island community does limit transferability of this project's findings. Using retrospective data also meant data collection was reliant on data being accurate, complete and available to review. Prescribers' narrative documentation, apart from the Hospice prescribers, were unavailable for review meaning a comparison between prescribing sources was not possible. The qualitative narrative documentation was not extracted using a proforma, which could have reduced the methodological rigor of these findings.

The quality statement by NICE (2017) and policy by GOJ (2022) was challenging to audit against, in comparison to a measurable standard that can be benchmarked. To evaluate individualised prescribing the qualitative narrative documentation was introduced to add context to prescribing decisions, alongside evidence of variation in medication choice.
Using a statement, instead of a standard also meant that this aspect of the project was more aligned to a service evaluation, rather than a clinical audit. Working as a palliative care CNS, data analysis was also at risk of being influenced through clinical knowledge of this field. However, it was ensured that conclusions and interpretations were based upon the findings of this project.

Conclusion

The findings from this clinical audit show that anticipatory prescribing was in place for patients in the audit sample. It was also shown that prescribing all core categories increased the likelihood of medication waste and the associated costs of this waste.

Even though almost half of all medications did result in waste, the findings demonstrated that not all waste should be viewed as negative. With reviewed records showing that some patients did not experience symptoms as they died, whilst others could still take their medications in oral form. This shows why clinical context through the introduction of qualitative data was important when analysing the quantitative data. The differences found in medication choice, and additional medications use did indicate that patient specific prescribing was present within the local area. But restricted access to prescribers' narrative documentation impacted the ability to evaluate this from all prescribing sources and determine alignment with local and national policy (GOJ, 2022) (NICE, 2017).

Implications of this study

The findings from this project do promote improvements to documentation, a collaborative approach to symptom assessment and a more regular prescriber medication review to strengthen local community services.

Implications for Advanced Practice

Through the ACP role, this can be applied through:
Leadership Pillar: Supporting the introduction of a collaborative symptom assessment tool
Clinical Pillar: Role modelling individualised prescribing, and promoting regular prescriber reviews
Education Pillar: Supporting other health care professionals with systematic assessments of patients, including communication and documentation of these assessments
Research Pillar: Conducting a re-audit on this topic to support service improvement

Recommendations

1. Continue alignment with local and national policy (GOJ, 2022) (NICE, 2017), ensuring that prescribing practice remains an individualised approach
2. The introduction of a community wide symptom assessment tool, used across all community teams, enhancing symptom reporting between professionals and documentation of symptom burden. It could also enhance prescriber medication reviews.
3. Re-audit - Once access to all narrative documentation is available, a re-audit on this topic would ensure a thorough evaluation of the local settings alignment with policy and presence of individualised prescribing (GOJ, 2022) (NICE, 2017).

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References