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**Title:**

**The importance of interdisciplinary communication in the process of anticipatory prescribing - a UK study of community health professionals**

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## **Abstract**

In the UK there has been a widespread introduction of 'anticipatory prescribing' in community based palliative care. This involves GPs writing prescriptions in anticipation of them being needed and has been encouraged to try to minimise the risk of patients suffering uncontrolled symptoms and distress, a key reason why terminally ill patients are admitted to hospital in contradiction of most people's preferences. This paper presents the findings from an ethnographic study of health care professionals across four care homes and four community sites in two regions (East Midlands and Lancashire/South Cumbria) of the UK. Data were collected from a range of community health professionals resulting in 83 episodes of observation and 72 interviews. Findings highlight how essential good interdisciplinary communication is to the process of anticipatory prescribing and end of life care. When interdisciplinary communication worked well the anticipatory prescribing process could be carried out smoothly, optimising patient care.

**Key words:** Anticipatory prescribing, 'just in case' medication, end of life care, communication, interdisciplinary working, community nursing

## Background

Viewed as a central part of palliative care in the community in the UK, the use of anticipatory prescriptions has been encouraged to help manage terminally ill patients' symptoms and distress (Wilcock, 2011, Department of Health, 2004, British Medical Association, 2012, National Institute for Health and Care Excellence, 2015). 'Anticipatory' or 'just in case' medications are prescribed in advance of common symptoms and are dispensed and held in the patient's home or care home for use when required. A study of the challenges in anticipatory prescribing reported by 63 community health professionals identifies anticipatory prescribing as a three stage process encompassing: writing a prescription, dispensing that prescription and then administering the medications, with potential for the process to 'fail at any of the three stages' (Faull et al, 2013:95) unless trusting and responsive relationships between professionals are in place.

Interdisciplinary working involves staff from different professional groups working together to share expertise, knowledge and skills for patient care (Nancarrow et al., 2013). The complexity of health care delivery and increasing professional specialisation poses particular challenges for team working (Poulton and West, 1999, Alsop, 2010, Al Sayah et al., 2014). These are especially pertinent in a context where patients are commonly older people with multiple morbidities where continuity of care is especially necessary (Nancarrow et al, 2013). The quality of palliative care provided to such patients is largely dependent on the capability of health professionals to create effective teams (Street and Blackford, 2001), but there are multiple barriers to the necessary communication practices, including difficulties in: face-to-face access, networking, transmission of information, as well as issues of territorialism. Moreover, it cannot be assumed that professionals share an understanding of each other's responsibilities or how 'quality' care can be achieved (Al Sayah et al., 2014). In the UK, palliative care focused initiatives such as the Gold Standards Framework (GSF) (<http://www.goldstandardsframework.org.uk/>) are being adopted in primary care. GP practices that sign up to the GSF receive training in end of life care for their generalist frontline staff. The programme

also incentivises GP practices to create a register of patients they considered to be within their last year of life. Multidisciplinary palliative care, or GSF, meetings are then set up to discuss the needs of these patients. These meetings are regarded as a platform for communication processes, enabling sharing of knowledge about patients with palliative care needs, problem solving and decision making (Mahmood-Yousuf et al., 2008).

While the literature referred to above clarifies the mechanics of team working, with some application to health care settings, there is little focus on palliative and end of life care. Street and Blackford report that interdisciplinary communication continues to be a 'major problem impacting on the health care provided to people at the end of life' (2001:643). This paper focuses on health professionals' perceptions of what facilitates and restricts interdisciplinary communication by using anticipatory prescribing as an exemplar of palliative and end of life care in the community. The findings illustrate how interdisciplinary communication is affected by: access to each other, whether health professionals were clear about each other's responsibilities and the degree of trust within their professional relationship.

### **Study design**

This is part of a wider study incorporating: 1). A literature review (Wilson and Seymour, 2013), 2). an ethnographic study using interviews and observations of those prescribing, dispensing and administering anticipatory medications, and 3). a postal survey of 575 community nurses (Wilson et al., 2016). In this paper we report on one of the key themes from the ethnographic study, with examples of qualitative data used as illustrations in the form of direct quotes from interviews and observational field notes.

### **Setting**

Two regions in England: the Lancaster /South Cumbria region covered a large semi-rural area serving a largely dispersed population, the East Midlands region was a socio-demographically varied area

with a dense and varied population in urban districts, as well as a more dispersed population in rural areas.

### ***Ethical approval***

We obtained ethical approval from the National Research Ethics Service (11/EM/0213) and governance approval from the NHS Trusts at each research site.

### ***Ethnography***

In each of the two geographic areas two community nursing teams and two care homes for older people registered to provide nursing care were purposively sampled (n=8 study sites). Study participants included registered nurses providing end of life care in each of the study sites (such as district nurses, care home nurses and specialist palliative care nurse), GPs responsible for anticipatory prescribing and community pharmacists responsible for the dispensing of medications. Data collection took place between December 2011 and May 2012 and was conducted by two researchers (EW and HM).

### ***Observations***

In order to gather contextual information and inform the interviews researchers shadowed nursing staff, attended meetings relating to prescribing, and observed drug rounds and discussions between staff about patient care, including communication with family carers. This allowed observation of incidences when prescriptions were written in advance of symptoms, as well as how, when, and in what circumstances the prescriptions were activated. Observations took place over approximately four weeks with each nursing and care home team. Each staff member gave written consent at the start of their involvement in the study and verbal consent was gained from those in the field of observation at any particular time. No intimate nursing care was observed. Patients and their family carers were provided with information about the study and asked to verbally consent to or 'opt out' of aspects of their care being included in the observations. A record of this decision was placed in patient's notes.

### *Interviews*

At each of the eight sites up to 15 nurses, GPs, and pharmacists were invited to take part in interviews both to complement the observational data and to gain their perceptions of the practical, organisational, ethical and communication issues they experienced. The researchers used an interview schedule to promote consistency across the two areas but were flexible to allow for interviews to be tailored to the individual. Interviews took place at the participant's place of work and lasted between 10 minutes and 2 hours. The majority of interviews were undertaken one to one and face-to-face. However, six small group interviews were held, four involved two nurses, one with three and one larger group of six. Six interviews were conducted over the telephone for the convenience of the participants. Five nurses were interviewed twice as directed by observations.

### *Data recording and analysis*

Hand written field notes were used to record observations. Field notes contained descriptions of actions undertaken by those being observed, as well as verbatim and annotated accounts of conversations, and the researcher's interpretive notes. Field notes were typed up, with careful anonymisation undertaken at this point. Interviews were digitally recorded and transcribed verbatim. All data were stored and managed in Nvivo9 (QSR International Pty Ltd, 2008). An initial coding framework was developed on the basis of a preliminary literature review (Wilson and Seymour, 2013) and through discussion at project meetings. This was adapted as data collection proceeded. Each data source was coded separately by EW and JS, codes were then compared, grouped into themes, and further distilled into categories. The process of analysis was discussed at dedicated project meetings, with validity of the resulting categories checked with the clinical project advisors and more broadly with an expert stakeholder group.

### **Data collection**

Across all eight study sites, 83 episodes of observation were conducted and interviews were undertaken with 72 participants. Interviews were conducted with a range of professionals including

community nurses (district nurses (n=27), care home nurses (n=16), specialist palliative care nurses (n=18)), GPs (n=8) and pharmacists (n=3).

## **Findings**

Health professionals participating in the study identified a number of barriers and facilitators to the anticipatory prescribing process. Each of these was underpinned by issues of communication. This article reports on this central theme from the findings of this study. Through in depth analysis and examination we were able to identify that respondents perceived three key issues to influence the quality of communication between them: access to each other, whether they were clear about each other's professional responsibilities and the degree of trust within their professional relationship.

## **Access**

GPs and community nurses regarded face-to-face access to each other as being the best channel of communication but achieving this depended on their physical location; in many cases, they were no longer co-located:

*I mean the whole issue regarding getting [anticipatory prescribing] forms to [the nurses] is totally different now, because I used to get a knock on the door and they would stand in here, we'd work through it together, we'd work out the doses together, whereas now it's always hard on the other end of a phone catching them and them catching me. ...having them working here in the same building in terms of communication was far better (GP interview)*

*We're no longer attached in a GP surgery. ...We're communicating with three separate GP surgeries that we can't access easily because we're [in a different building]. (District nurse, interview)*

Conversely, some policy changes were thought to aid communication by improving access. For example, in one area care homes were switching to a system of registering all their patients with a single GP practice. This system was perceived to have enabled relationships to be built between GPs in that practice and the care home nurses. Where the allocated GP surgery was also in physically close proximity -as one nursing home reported- this was regarded to be an additional benefit:



*And of course if you're dealing with the same practice all the time, then they build up confidence in you as you build up confidence in them, it just makes a better working relationship so they will know we wouldn't ask for [anticipatory prescriptions] unless we thought we needed them. (Care home nurse, interview)*

Geographical proximity was considered particularly helpful for informal communications and 'corridor conversations'. However, more formal occasions for communication such as those afforded by the palliative care/GSF meetings were also perceived by participants to offer opportunities to communicate effectively. Tasks could be allocated, patient care discussed and collaborative decisions made:

*Well in our practice we have regular Gold Standard Framework meetings where we keep up to date on what's happening with the patients. ...the district nurses normally let me know when anticipatory drugs are needed. Or if I happen to visit somebody because they're getting worse and I think the anticipatory drugs are needed I'll speak to district nurses but do the prescription. (GP, interview)*

Nurses reported that they often initiated conversations about getting anticipatory prescriptions in place at these meetings. GPs concurred, as nurses often spent more time with patients, that they were well placed to prompt the GP to begin the process.

*Quite often the district nurses have been more involved with patients, so quite often they'll say 'look I think they're deteriorating, we probably ought to put [an anticipatory prescription] in'. (GP interview)*

### **Clarification of responsibilities**

Having a clear understanding of each other's responsibilities in the anticipatory prescribing process was perceived to be an important factor in good interdisciplinary communication. Trust could be challenged by poor understanding of the differing responsibilities undertaken by GPs and nurses. This difference was particularly manifest in the prescription writing phase of the process, with nurses reporting that prescriptions were incorrectly written in a number of instances. GPs seemed to be willing to work within a small level of risk and reported being frustrated by nurses continually bring prescriptions back to be rewritten because of small errors. Correcting these issues could be frustrating process for all health professional involved and was often hindered by access issues:

*Usually speaking, if we get a form right, it's usually cause for celebration. ...just because certainly all of the 'I's and all of the 'T's definitely have to be crossed. I'm not sure they*

*actually definitely have to be crossed but our district nurses feel that they actually have to definitely be crossed. ... It's just that sometimes you just make a minor mistake on that and so we have the phrase of 'faxing tennis' really where the form just goes backwards and forwards and backwards and forwards, which can certainly be frustrating. (GP, interview)*

The [anticipatory prescribing form] issue has raised its head again ... [Got to seek] out a GP in the building who is prepared to rewrite it again, or going to the other surgery site where there will be a GP available – but both take extra time out of a busy day. (District nursing team, Observation field notes)

Nurses and pharmacists highlighted the legal requirements of prescriptions and the potential impact on their professional registration if they administered from a prescription that was not written correctly:

*...then the GP makes you feel like you're hassling them, 'you've not done this prescription properly, please could you rewrite it?', and you get ... 'Surely you can just use it?', and you're thinking 'well no it's not legal; I've got no cover with this prescription'. (District nurse, interview)*

*I think sometimes doctors don't seem to understand the importance, the legal requirements of doing a controlled drug prescription. For example the validity, there's got to be directions, dosage, quantity, they've got to be in words and figures. ...There's times when prescriptions come from surgeries that haven't been signed, where legally you cannot dispense it then. (Pharmacist, interview)*

### **Trust**

Trust, access and clarification of responsibilities were considered to be interlinked and comprise a central component of interdisciplinary communication. In order for nurses to initiate the anticipatory prescribing process the GPs must agree with the suggestion that one is needed. Many community nurses in the study reported good working relationships with GPs and reported that GPs were happy to take advice on when to instigate anticipatory prescriptions. GPs reported referring to their community nursing teams and local supporting documentation for advice and guidance:

*Well, we're quite lucky in that we have a dedicated palliative care specialist nurse team that deal with the care homes, ...they help us guide us ... They do it on a day to day basis so they become very proficient at it and they know how to do it very well. ...So why not turn to their expertise? (GP, interview)*

However, nursing participants reported that a small number of GPs were reluctant to prescribe anticipatory medications. Both nurses and GPs recognised that GPs did not regularly prescribe these drugs and therefore sometimes lacked confidence to write prescriptions without guidance:

*Some GP's are quite reluctant, others are fully on board ...It's just experience, and perhaps they are not up to date with the training etc. and I think sometimes they're a bit reluctant because they are not quite sure (Care home nurse, interview)*

Although many of the district and community nurses in the study had no specific training in palliative or end of life care they had a great deal of experience in this area. Yet some reported feeling undervalued and not listened to, believing that their knowledge and skills were dismissed by GPs:

*Perhaps they just don't like being told what to do by nurses (District nurse, interview)*

This seemed to stem from a hierarchical attitude to interdisciplinary working and a poor understanding of differing responsibilities, resulting in limited communication and preventing trusting relationships from being built. Although an established relationship was an important element of trust, in its absence it was apparent that having additional palliative care training or experience engendered greater levels of trust from GPs. Some participants indicated that GPs may lack confidence in the generalist nurses' abilities to appropriately administer the prescribed drugs. In these instances the support of a specialist palliative care team could help mediate. This was mainly reported by the care home nurses in the study.

*I think they tend to get confidence in who's asking, so if you've got a carer in a care home asking for it ...GPs are reluctant to do it, but when you've got somebody like myself just because you've got the 'palliative care' title they feel maybe more confident to do it. ...they're actually prescribing and signing to a drug that probably they don't use that often, so it is trust. (Specialist palliative care nurse, interview)*

## **Discussion**

Qualitative data has been presented from the ethnography in the form of direct quotes and observation field notes. These data have demonstrated that for interdisciplinary working to be effective and anticipatory prescribing to benefit patients, good communication between professionals is essential throughout all stages of the process. The findings illustrate how the quality of interdisciplinary communication is affected by: access to each other, whether health professionals

are clear about each other's responsibilities and the degree of trust within their professional relationship.

Despite the prevalence of computers and mobile phones health professionals in this study reported that face-to-face communication was still the more effective form, through both formal and informal access to colleagues. General care planning discussions and palliative care meetings were perceived to facilitate this process and face-to-face contact aided relationship building between team members, echoing research by Al Sayah et al. (2014). Staff from GP practices in this study that held GSF or palliative care meetings considered these to legitimise time for discussing patient cases (McClelland et al., 2008). For example, nurses reported that they felt able to express views and share information in these types of meeting. Many staff reported instances of joint and supported decision-making, potentially reducing the emotional burden on staff (Rafferty et al., 2001).

For staff in this study, physical proximity promoted the quick resolution of issues with prescriptions. However, the decentralisation of professionals to different locations was reported to pose challenges for easy communication. In a qualitative study of 38 community health professionals Mahmood-Yousuf et al. explored the extent to which the incorporation of GSF into GP practices influenced interprofessional relationships and communication. Findings from their study suggest that important informal communication could be put at risk 'as practice-based district nursing services in the NHS may be increasingly threatened by the 'corporatisation' of district nurses into area teams' (2008:262).

Findings in this study have shown that clarity in understanding of differing multidisciplinary responsibilities can affect communication. Al Sayah et al. (2014) suggest that a lack of trust, especially between nurses and physicians, is often due to a lack of clear role descriptions and division of labour. Indeed, in this study pharmacy's role was often alluded to as peripheral and respondents appeared to have little knowledge of the legal status of prescriptions. The dis-alignment of views in what was considered an acceptable margin of error between GP and nurses created

considerable burdens in terms of time and energy in getting usable prescriptions. These issues were often compounded by limitations in access to the appropriate professionals.

GPs in this study expressed the need for an established relationship with nurses in order to trust their opinions and feel confident that a prescription would be administered correctly. However, there was evidence in this study, echoed in research by Mahmood-Yousuf et al.(2008), that there remains an imbalance of power, particularly between GPs and community nurses, based on traditionally perceived hierarchies of the primary health care team. Some nurses in this study reported that some GPs did not like to take direction from nurses. This appeared to be more commonly reported by care home nurses. However, nurses with additional specialist palliative care training were perceived to have more knowledge, therefore engendered greater trust from GPs and often facilitated between care home nurses and GPs. These findings support those of a wider evaluation study to assess quality of end of life care for those with dementia in the North East of England (McClelland et al., 2008). That study found that levels of conflict between staff were low, however when it did occur it was due to anticipatory prescribing and pain management of patients. Moreover, that study also reported that 'GP's confidence in the ability of care staff to manage symptoms and use medication appropriately required a trusting and professional relationship' (McClelland et al., 2008:96). In some care homes these relationships may be inadequate due to high staff turnover (Tilden et al., 2012, Finucane et al., 2014), or care home staff having limited knowledge of palliative care drugs and how to control symptoms (Watson et al., 2006). However, findings from the study reported here show that communication and trust between GPs and care home nurses was facilitated by a move to a single GP practice.

There is conflicting evidence of the effects of team working on patient care (Mahmood-Yousuf et al., 2008), yet there is evidence of the impact on the working lives of the team players. As Rafferty et al. note good team working increases job satisfaction, the likelihood of a nurse remaining in their role and reduces stress related burnout. Rafferty et al. also found that team working and autonomy work in synergy rather than conflict - promoting nursing autonomy is a way to enhance interdisciplinary

working rather than undermine it (Rafferty et al., 2001). Those working in better functioning community teams may be more likely to feel confident in making autonomous decisions about the use of anticipatory prescriptions (Wilson et al., 2015). As such we can see how specialist palliative care teams can provide essential advice and support to 'generalists' delivering end of life care in the community and using anticipatory prescriptions.

### **Implications for practice**

Recent NICE guidance advocates staff utilising training programmes to support anticipatory prescribing (National Institute for Health and Care Excellence, 2015). At a dissemination event for professional stakeholders contributors advocated for shared training, indicating that separate training and education for different professions resulted in limited knowledge of the other's responsibilities. However, evidence from this study shows that training only supports those who have time to access it, a constant challenge for all health care professionals. While training is of course important, mechanisms for formal and informal access to each other seemed to be a more pragmatic and successful way to share knowledge. GSF style meetings and single GP providers to care homes seem to be particularly useful ways of facilitating interdisciplinary communication. Yet there needs to be further recognition of the importance of informal interactions in creating a foundation of better understanding of different professional roles, forging relationships, and building trust with colleagues.

### **Strengths and Limitations**

This paper has presented the views and opinions of a range of professionals involved in anticipatory prescribing. However, nurses' views are dominant as they made up the majority of participants. The triangulation of multiple sources and types of data collection is a key strength of the study.

Moreover, it is of course important to note that accounts of problems are often easier to recall and are more noteworthy than those when the process has run smoothly. In addition some questions were designed to illicit the challenges for nurses as well as to highlight good practice. Therefore,

narrative accounts may be swayed towards the problematic aspects of practice in this area of end of life care.

## **Conclusion**

It is already clear that good interdisciplinary communication plays an important role successful health care delivery. Findings presented here have illustrated that GPs work with a number of different nurses and vice versa. This obligates them to negotiate different relationships with each other, making the achievement of a high functioning interdisciplinary team a constant challenge. However, good interdisciplinary communication has been shown to support all elements of the process of anticipatory prescribing as well as the professionals delivering care. Trust empowers nurses to make decisions that are supported by medical and nursing colleagues. It is earned and supported by good access to team members, both formal and informal. Understanding of each other's responsibilities and an established relationship supports open communication by flattening the hierarchy of clinical power. Narratives from this study are littered with references to communication in the process of anticipatory prescribing for end of life care. In exploring these interview narratives and observational data we have drawn together an understanding of how respondents perceived three key issues to influence the quality of communication between them: access to each other, whether they were clear about each other's professional responsibilities and the degree of trust within their professional relationship.

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