‘Top-tips’ for best practice and areas in need of improvement in AP

Findings from previous workshops

Association for Palliative Medicine

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On behalf of: Palliative and End of Life Care Research team (group lead: Dr. Stephen Barclay)

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Public Health and Primary Care
The Primary Care Unit

Background

- Workshop events: April 3rd (London) and May 1st (Cambridge), 2019
- Supported by the APM, funded by Marie Curie and attended by Prof Bee Wee (National Clinical Director for End of Life Care, NHS England)
- Aims:
    1. To explore the views of UK healthcare professionals (HCPs) about best practice and areas in need of improvement in AP
    2. To explore the need for further guidance in AP

What happened?

- 89 participants: HCPs, PPI x2, researchers, policymakers, design engineers
- 71 survey responses (HCPs)
- 30 focus groups

Baseline attitudinal survey

Focus group 1:

'best practice' in AP

Focus group 2:

'areas in need of improvement' in AP

3 'Top-tips' for achieving best practice *(what and/or how?)*

3 'Top-tips' for areas in need of improvement *(what and/or how?)*

Thematic analysis of free-text top-tips (NVivo12)

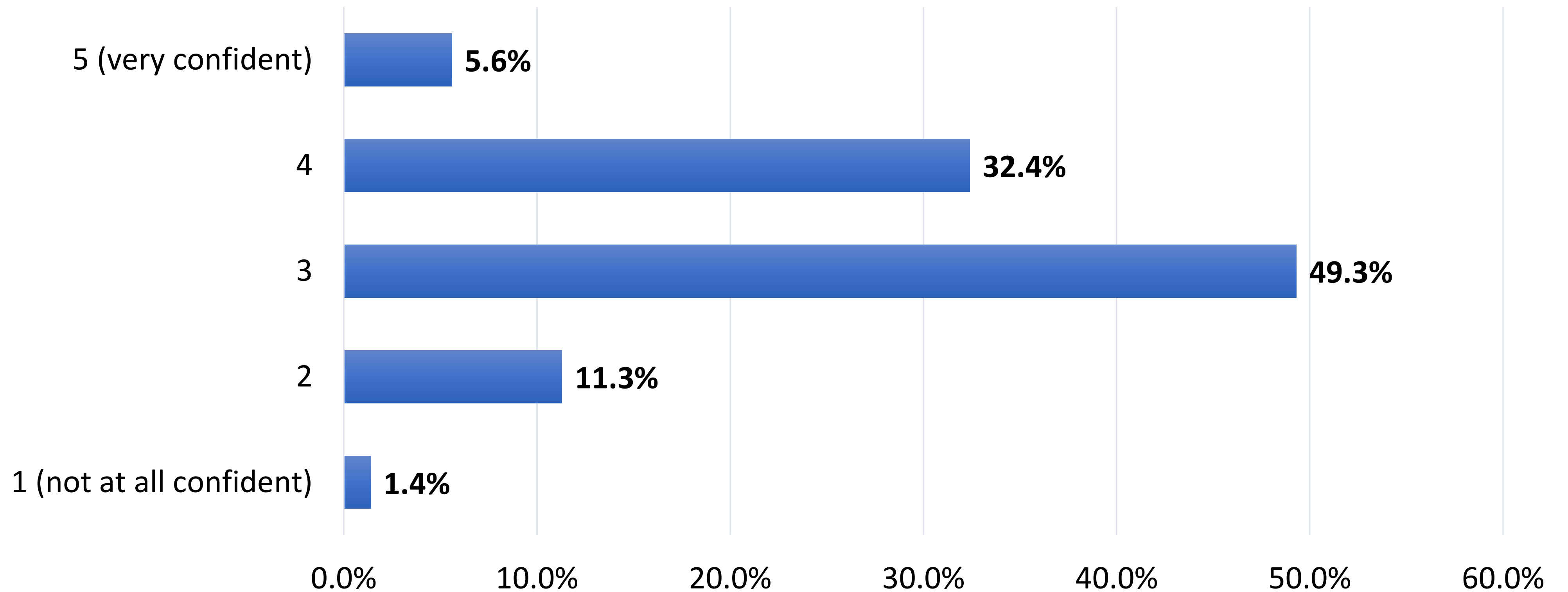
Attitudinal survey results

Attitudinal survey: sample characteristics (n=71)

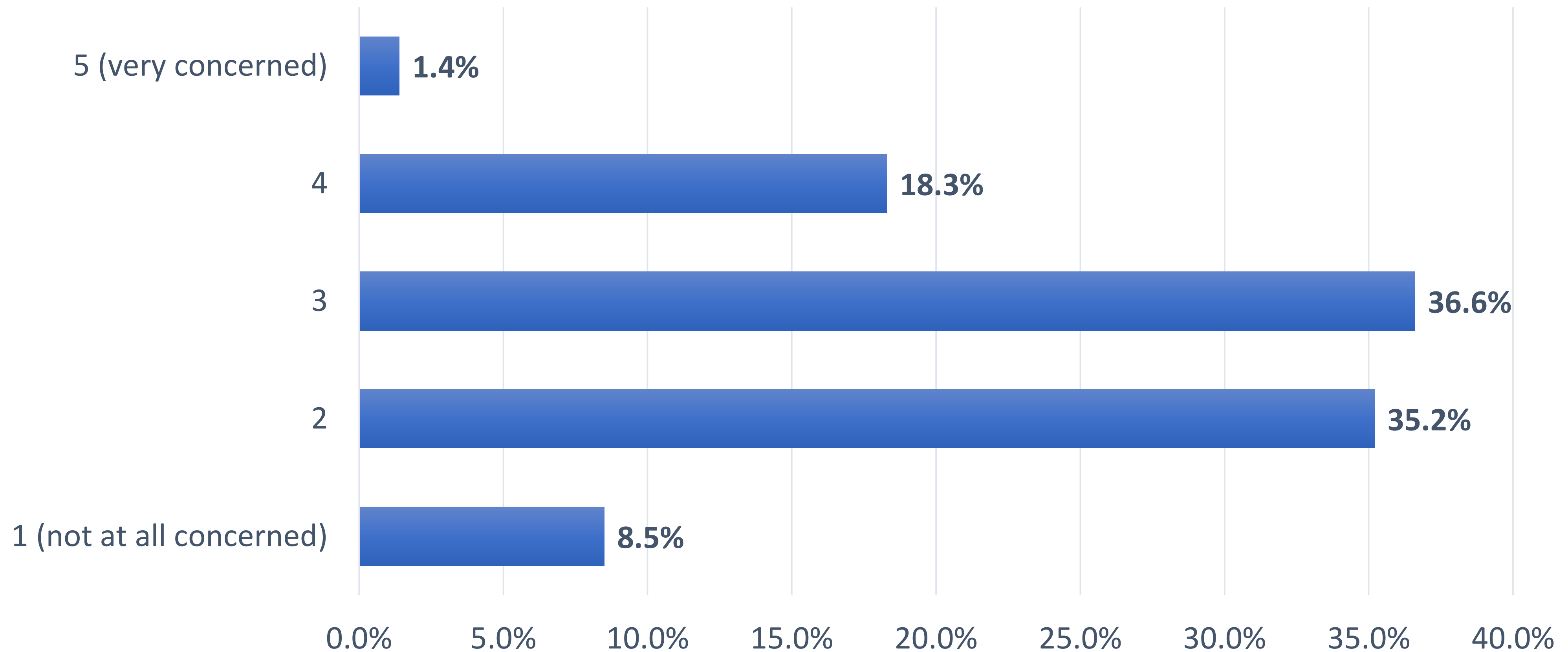
	N (%)
Profession (n=71)	
Senor Pall Care Nurse	25 (35)
Consultant	24 (34)
Community Nurse	7 (10)
GP	6 (9)
Pharmacist	4 (6)
Non-consultant doctor and nurse ’other’	5 (7)
Workplace setting (n=70)	
Community care alone	36 (51)
Inpatient care alone	9 (13)
Combination	25 (35)

	N (%)
Years of experience in End of life Care (n=71)	
0-5 years	7 (10)
6-10 years	10 (14)
11-15 years	10 (14)
16-20 years	11 (16)
>20 years	33 (47)
Involvement in aspects of AP (n=71)	
A few times each week	53 (75)
A few times each month	9 (13)
A few times each year	8 (11.)
Every few years	1 (1)

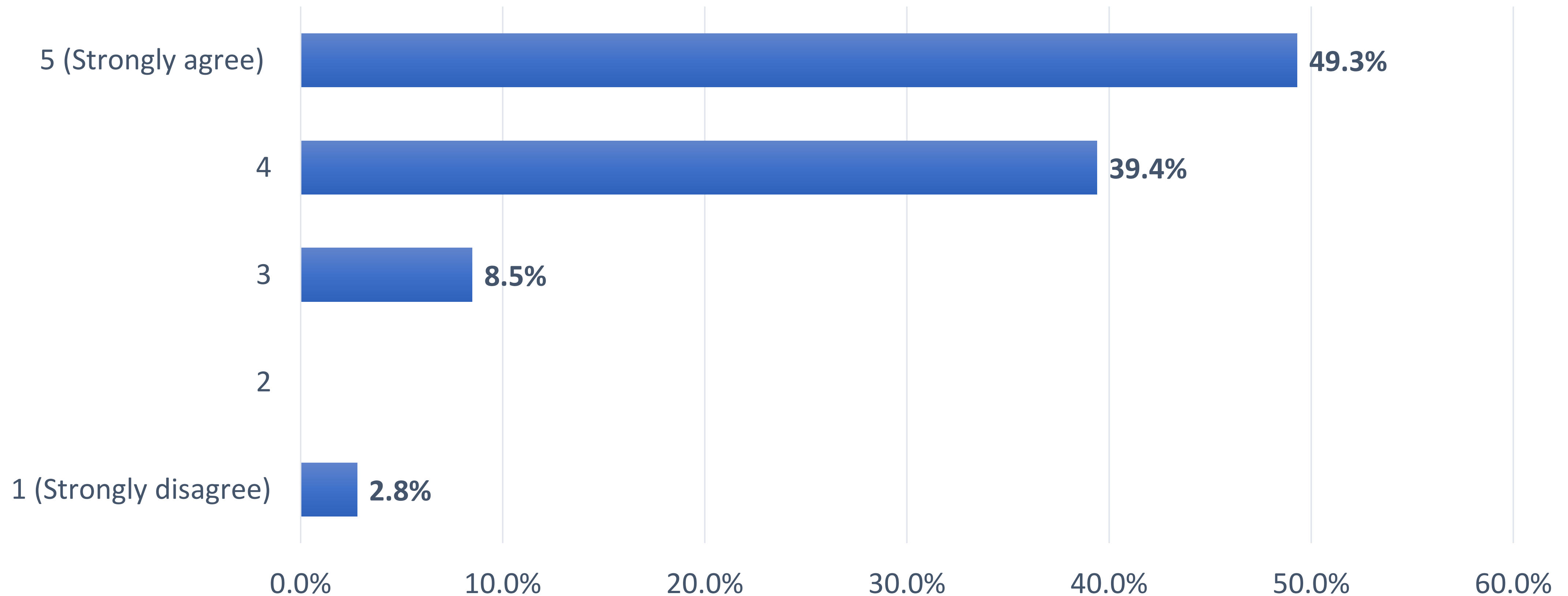
Attitudinal survey results: Q1



Attitudinal survey results: Q2



Attitudinal survey results: Q3



'Top-tips' analysis

‘Top-tips’: what does best practice look like?

‘same by default at system-level and different where needed’ (April)

Right treatment

- Timely: not too early or late
- Appropriate to need
- Patient and carer involvement
- Standardised AND individualised

Right people

- Competent and confident staff
- Optimal use of specialists
- Excellent communication between all parties

‘Trained team in community to administer medication with robust support at specialist level’ (April)

‘nurses to be supported by policy and training to administer AP’ (May)

Right resources

- Adequate staffing levels
- Guidance
- Training and education
- Shared documents and IT systems
- Access to specialist support
- Easy access to medications

Right system

- Cross-setting working
- Collaborative working
- Clear roles and responsibilities

‘Integrated work across hospice, community and hospice’ (April)

‘Shared governance risk across systems’ (May)

‘Top tips’: what needs to be improved?

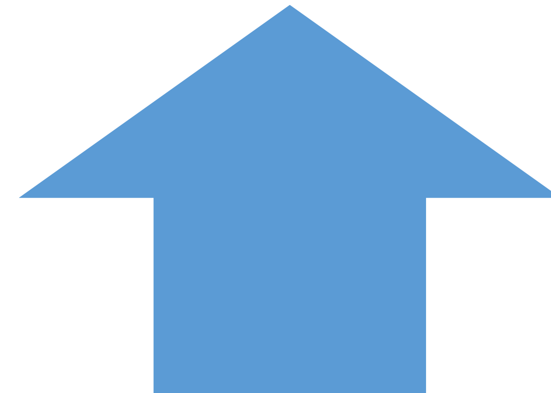
2 broad categories of concern

‘The harm of ***not having*** AP’

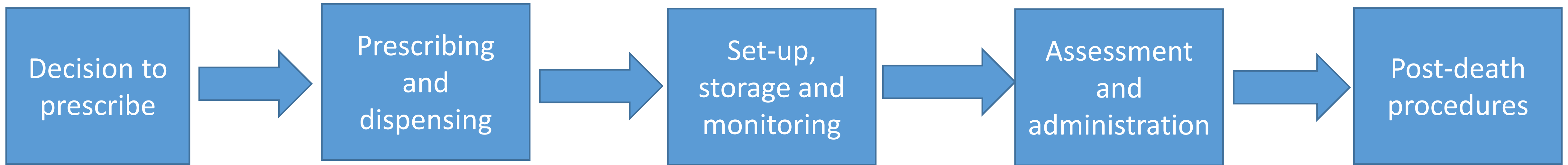
AP is delayed, blocked or omitted: patient in distress without any treatment

‘The harm of ***having*** AP’

AP in place BUT unsafe: patient receives inappropriate treatment



‘Harm of *having* AP’= ‘*quality* of the elements’



- ❑ **Too early and not discussed with patient/family**

‘Too early in the house for sure i.e. all those going home on Fast Track have injectables…family not clear’
(Pall Care CNS, May)

- ❑ **No assessment**
- ❑ **Inappropriate prescribing- doses, medicines, ranges**
- ❑ **Hidden prescribing adjustments**

‘Poor prescribing e.g. large ranges, inappropriate meds and lack of review’
(Consultant, April)

- ❑ **Drug diversion**
- ❑ **Lack of review of prescription**

‘Drugs going missing: [need] some system of checks of available drugs’
(Consultant, May)

‘Things change: need review to avoid inappropriate use’
(Non-consultant doctor, May)

- ❑ **Lack of assessment**
- ❑ **Inexperienced assessment**
- ❑ **Inappropriate administration**
- ❑ **Hidden practice**

‘Reliance on least experienced person (e.g. band 5 DN) making decisions about dose within a range’ (Consultant, April)

‘Lack of oversight of administration: lack of audit trail….’ (Consultant, April)

- ❑ **Lack of clear guidance**

‘Safe disposal of unused anticipatories after the patient has died. Whose responsibility is it? This needs to be regulated’
(Consultant, April)

‘Harm of ***not having*** AP’= ‘***connectivity*** of the elements’

- ❑ **Too late or not made at all**

‘Not thinking far enough ahead/waiting for certain poor prognosis’ (Consultant, May)

- ❑ **Cannot access suitable prescriber**
- ❑ **Cannot access medication**

‘Lack of prescribing knowledge by GPs: Delays process- they are reliant on others’ (Community nurse, April)

‘Medicines run out and not available locally’ (Senior nurse, April)

- ❑ **No administration chart**
- ❑ **Carer doesn’t know who to contact**
- ❑ **Nobody available to administer**

‘Drugs prescribed (FP10) but authorisation not done’ (Consultant, May)

‘AMs may be in place but the HCP is not- relatives have reported difficulties in obtaining help’ (Pall Care Nurse, May)

Causal factors: same for both types of harms

1) Lack of uniform guidance

'Different medications in different settings- [need] professional consensus re meds' (Consultant, April)

2) Lack of suitably trained, knowledgeable staff

*'Drugs being given by **staff with little/no confidence-** task-orientated without personalizing'* (Senior nurse, May)

3) Poor communication

'Lack of communication between pharmacists, GPs and consultants' (Pharmacist, April)

'Medications not being explained to family/patients- just given and left…..' (Senior nurse, May)

4) Limited availability of medications

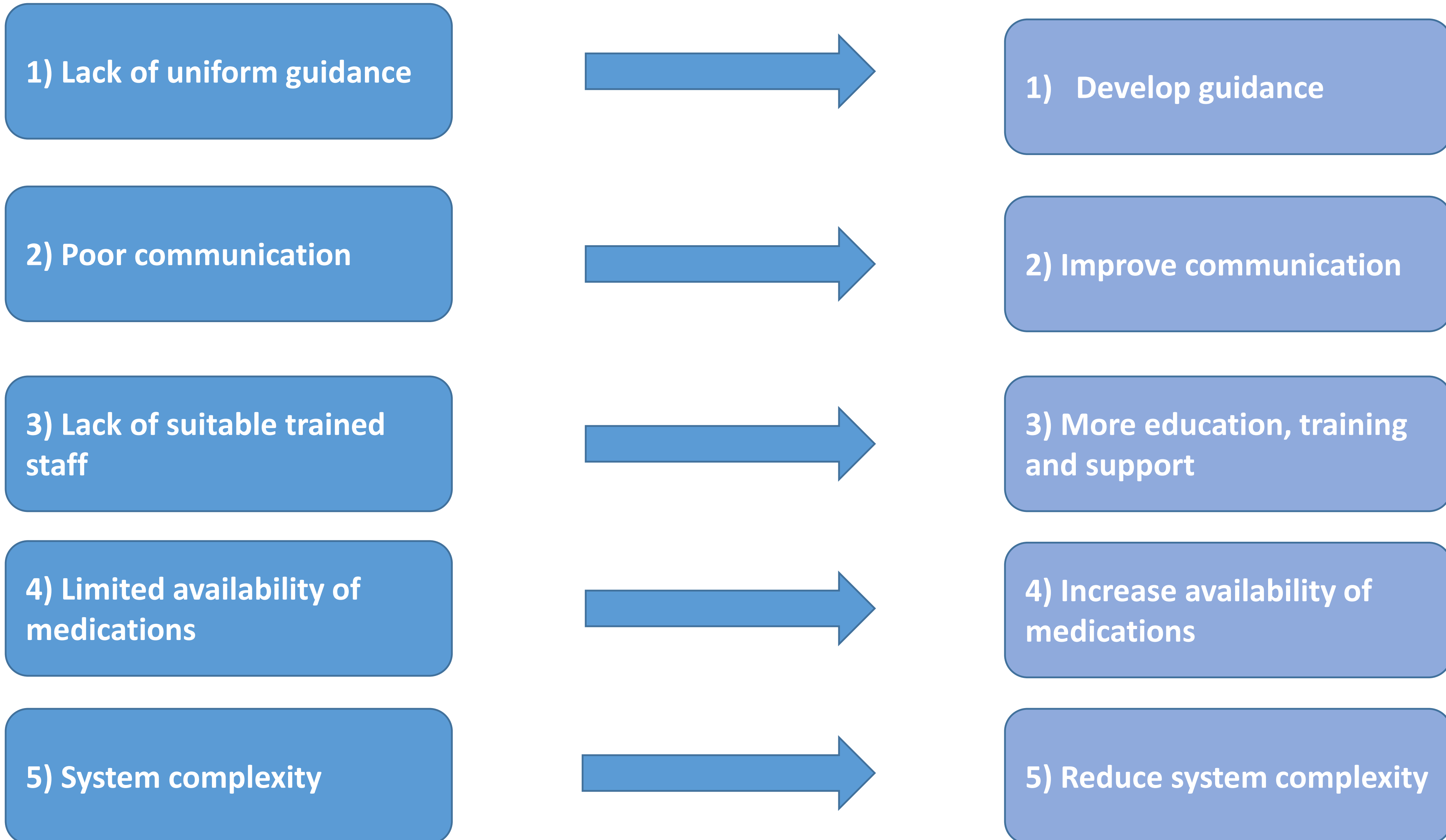
'Lack of pharmacy/medication stock' (GP, April)

5) System complexity

*'….**too many cooks** lead to delays!'* (Consultant, May)

*'Difficulty in system to ensure documentation is correct- **too many steps**'* (Consultant, May)

'Top-tips': how do we improve AP and achieve best practice?



Recommendations- specifics

1) Develop guidance

- National or regional
- Proposed reasons: to address variation across settings, to provide *standards of what to expect*, to provide a standardised '*framework for individualized practice*', *'to support generalists'*
- Areas that need addressing: when to prescribe, prescribing, administration, when to seek help, monitoring, drug disposal, communication, settings/services involved
- A desire for standardised guidance: '*Accompanying charts, paperwork, teaching*'

2) Improve communication

- Communication with patients and carers: '*standardised patient information leaflets and procedures'*
- Communication between teams and across settings: '*single electronic share record'* (for prescribing/administration/patient information)
- Generalists and patient/carer able to access skilled advice: *'24-hour contact lines and fast response'*
- More joined-up MDT working with '*engagement of patient's own GP'*
- Adequate staffing levels (having the time to do AP without it being rushed!)

Recommendations- specifics

3) Training, education and support

- Standardised: *'Training health professionals with unequal skills to the same level', 'national recognised training'*
- Training for all: non-specialists (GPs, DNs), patients, carers, paramedics
- Areas for training: prescribing, administration, purpose, communication skills around initiation of AP
- Mandatory, protected, joint learning: *'[GPs need] protected time for learning in AP', 'joint learning and reflection'*
- Support for workforce: *'24-hour access to support'*

4) Improve access to medications

- Access to stock: *'Central points for drugs to be kept', 'Having a rotation of local pharmacies who stock EOL medication'*
- Access to prescriber:*'24-hour access to prescribers with appropriate knowledge and skills'*

5) Reduce system complexity

- *'Eliminate as many steps as possible in the process':*
- IT systems to reduce prescribing errors and improve communication
- Shared and reduced number of documents across settings
- One point of contact for help
- Shared governance across settings, with clear roles and responsibilities

Limitations

- Sample: self-selecting, the majority of whom were palliative care specialists
- Focus groups took place after morning presentations about AP: content may have influenced views of participants
- ‘Top-tips’ format lacks contextualisation
    - In depth analysis of the focus group transcripts is taking place, which will contextualise these findings and provide rich examples from practice.

In summary: best practice in AP- the building blocks

Acknowledgements:

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