2. Anticipatory Prescribing practice pre and post COVID: where are we now? A national survey

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Background

- **Palliative and end of life care** aims to alleviate suffering and care for the person and their family, in their preferred place of care, throughout the disease trajectory and after death

- **Anticipatory prescribing** refers to **injectable medications** prescribed ahead of clinical need, "just in case", for administration by nurses and doctors if symptoms arise in the final days of life.

- Evidence of best practice is scarce although AP is performed every day across the region.

- Despite NICE Guidelines and regional guidelines and policies we know there is variation in practice.

Bowers 2019, 2020
Ryan 2020

AP Focus Groups study - UNPUBLISHED

Aim: to explore what healthcare professionals, working in different palliative and end of life care settings, consider to be **best and poor** anticipatory prescribing practice

Methods: Thematic inductive analysis of 30 focus groups with 6-9 participants each, digitally recorded and transcribed verbatim. Codes were developed, compared and discussed in order to group them into categories and finally into themes using Braun and Clarke's six phases: data familiarisation, generating initial codes, constructing themes, reviewing potential themes, defining and naming themes, producing the report

Results: 3 overarching themes - definition of anticipatory prescribing, best practice and poor practice.

4 categories for **best practice**: continuity of the process, audit/monitor practice, coordination/shared decision, safety and flexibility.

5 categories for **poor practice:** plethora of policy/guidance and guidelines, lack of evidence, complexity of anticipatory prescribing being a process within a system, responsibility of each role and system level Inequalities

Results

- Definition of anticipatory prescribing

  "although you put a very good definition of anticipatory prescribing, half the table thought we were talking about syringe driver medication. And PRNs associated with that." [Group number 2A May - speciality doctor in palliative care working at hospice, General Practitioner background]

- Best practice

  "So ideally everybody is working to the same standard operating procedure with the same level of knowledge and the same degree of communication skills." [Group number 1A May - Palliative Care Nurse specialist, background is cardiac nursing]

- Poor practice

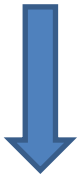
  "we've got the GP and the community nurses, and possibly the palliative care nurses if they are a different trust, so you've probably got three players, but you might even have the out-of-hours doctor, so that's at least four players, and you might even have [Ambulance Service Name], if you're asking them they may even go to administer medications, at least five players.". [Group number 1B April - Consultant in palliative medicine (hospital, community, hospice)]

Discussion

- This study provided detailed views of what HCPs, working in different palliative and end of life care settings, consider to be best and poor AP practice.
- There is variance in AP practice, namely in clinical decision making, due to a lack of a similar working definition of AP, resources available in different care providers and geographical regions, level of training and coordination of all involved.
- One of the main issues that needs addressing to reduce errors is standardisation of processes and services offered.
- The more players and steps involved, the bigger the chance for mistakes. However, AP practice must always be tailored to the individual patient and their context.

There is variance in practice across the nation

Evidence of best practice is scarce



Add a pandemic!

https://spcare.bmj.com/content/early/2020/06/15/bmjspcare-2020-002394

Aim

To investigate the experiences of clinicians in UK and Ireland regarding changes in AP during the COVID-19 pandemic and their recommendations for change

Methods

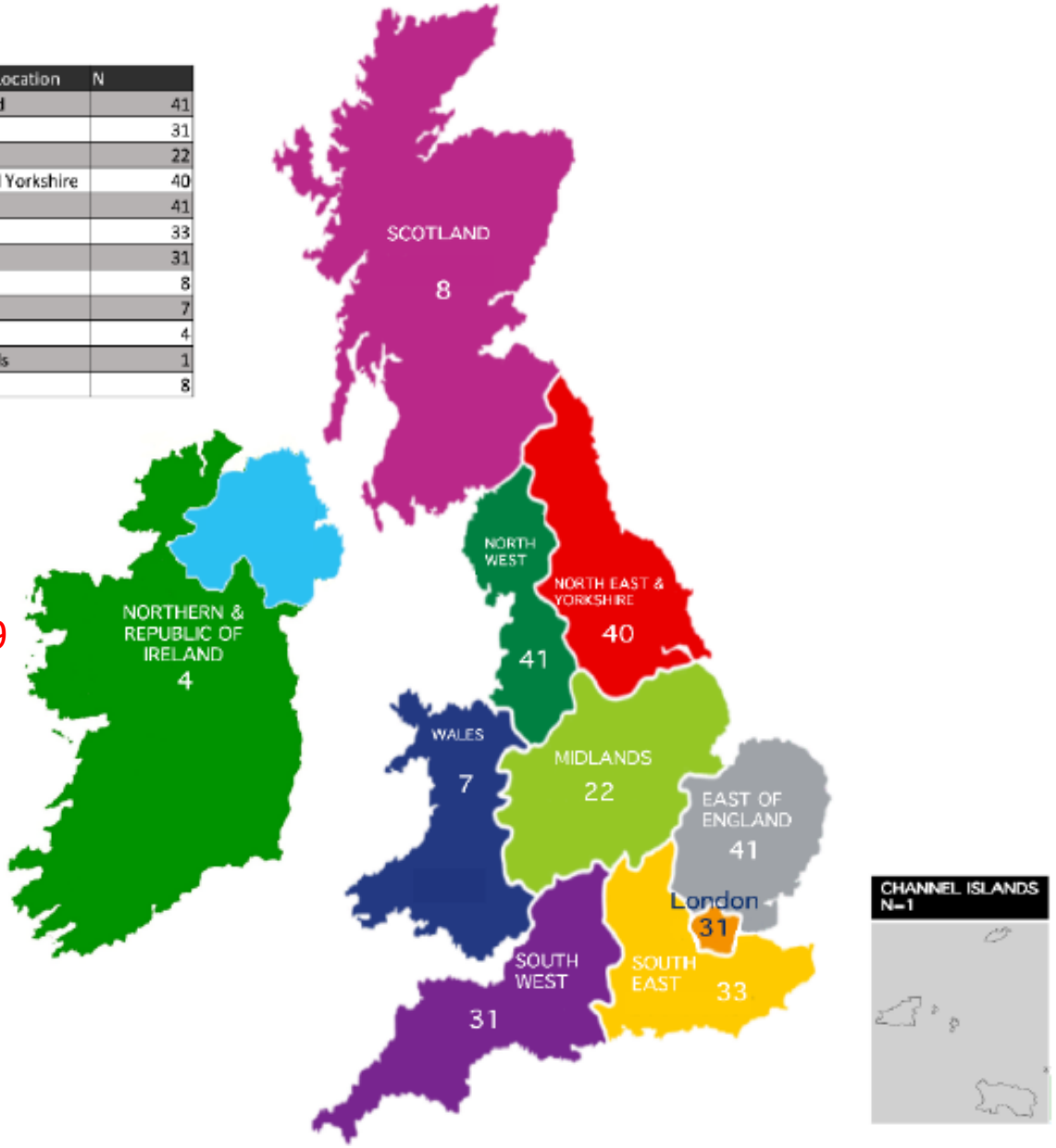
- Online survey
  - participants from previous AP national workshops
  - members of the Association for Palliative Medicine of Great Britain and Ireland
  - other professional organisations

snowball sampling

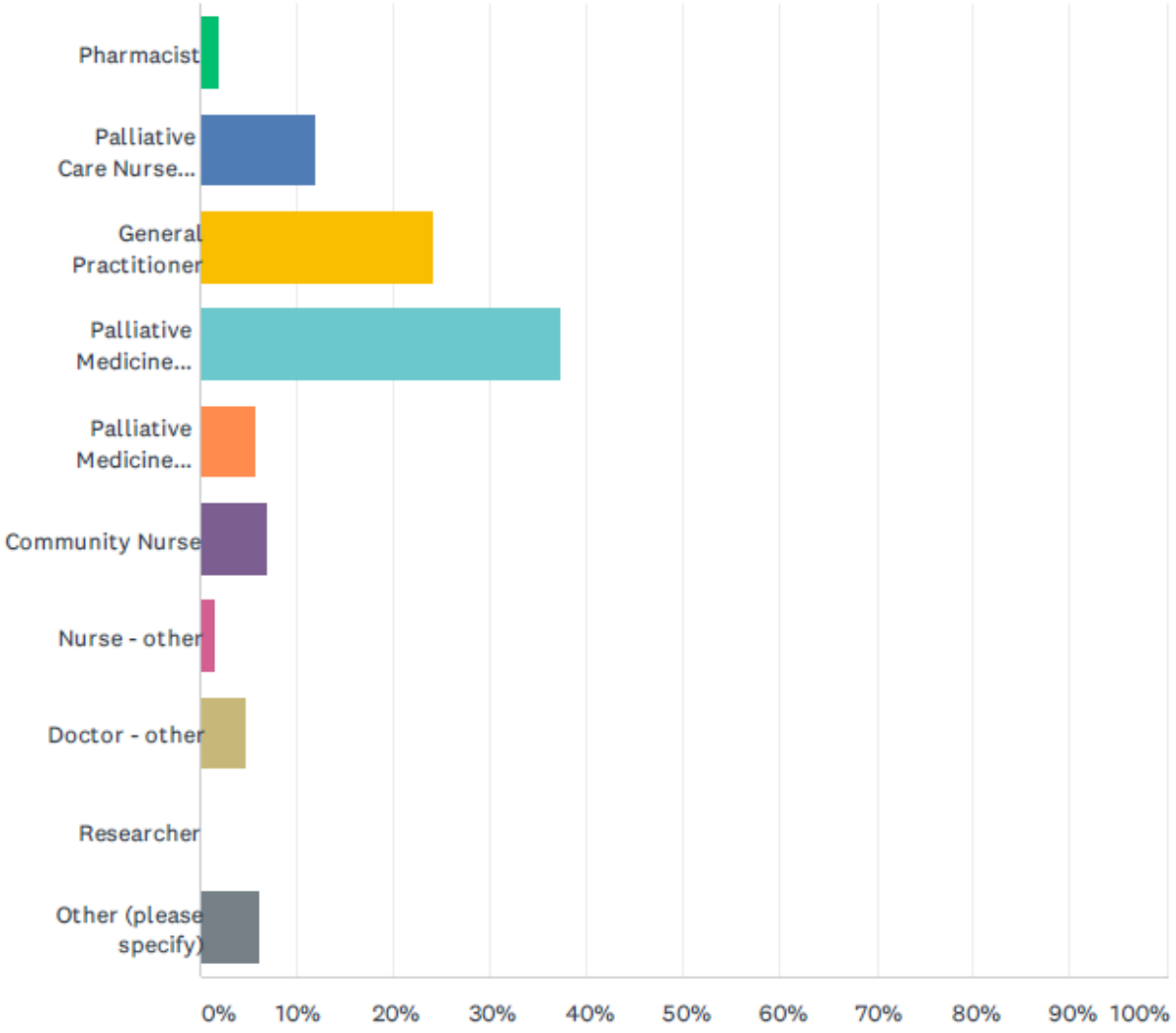
Results

Geographical Location	N
East of England	41
London	31
Midlands	22
North East and Yorkshire	40
North West	41
South East	33
South West	31
Scotland	8
Wales	7
Ireland	4
Channel Islands	1
Other	8

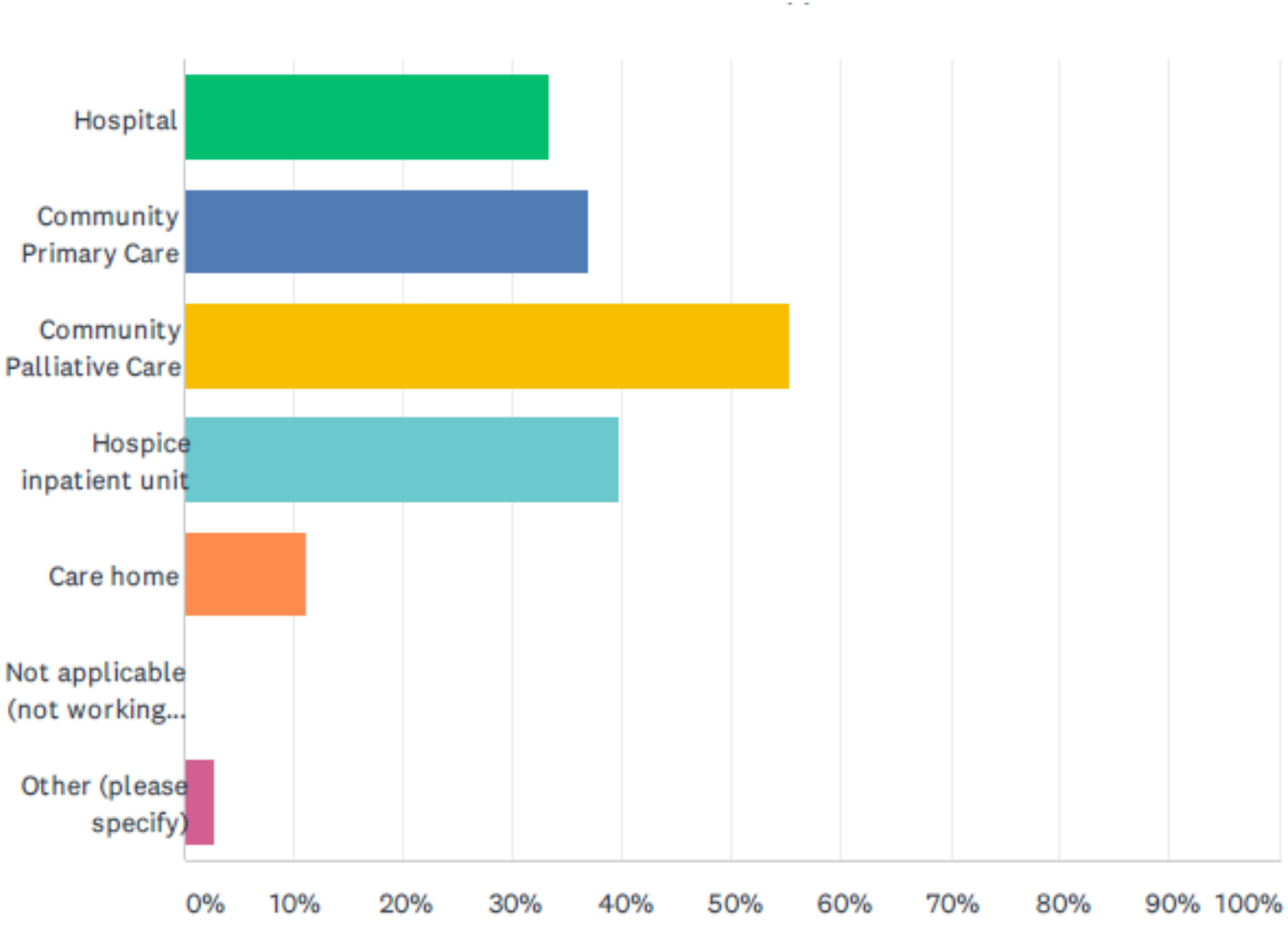
261 respondents between 9 and 19 April 2020 working in community, hospice and hospital settings



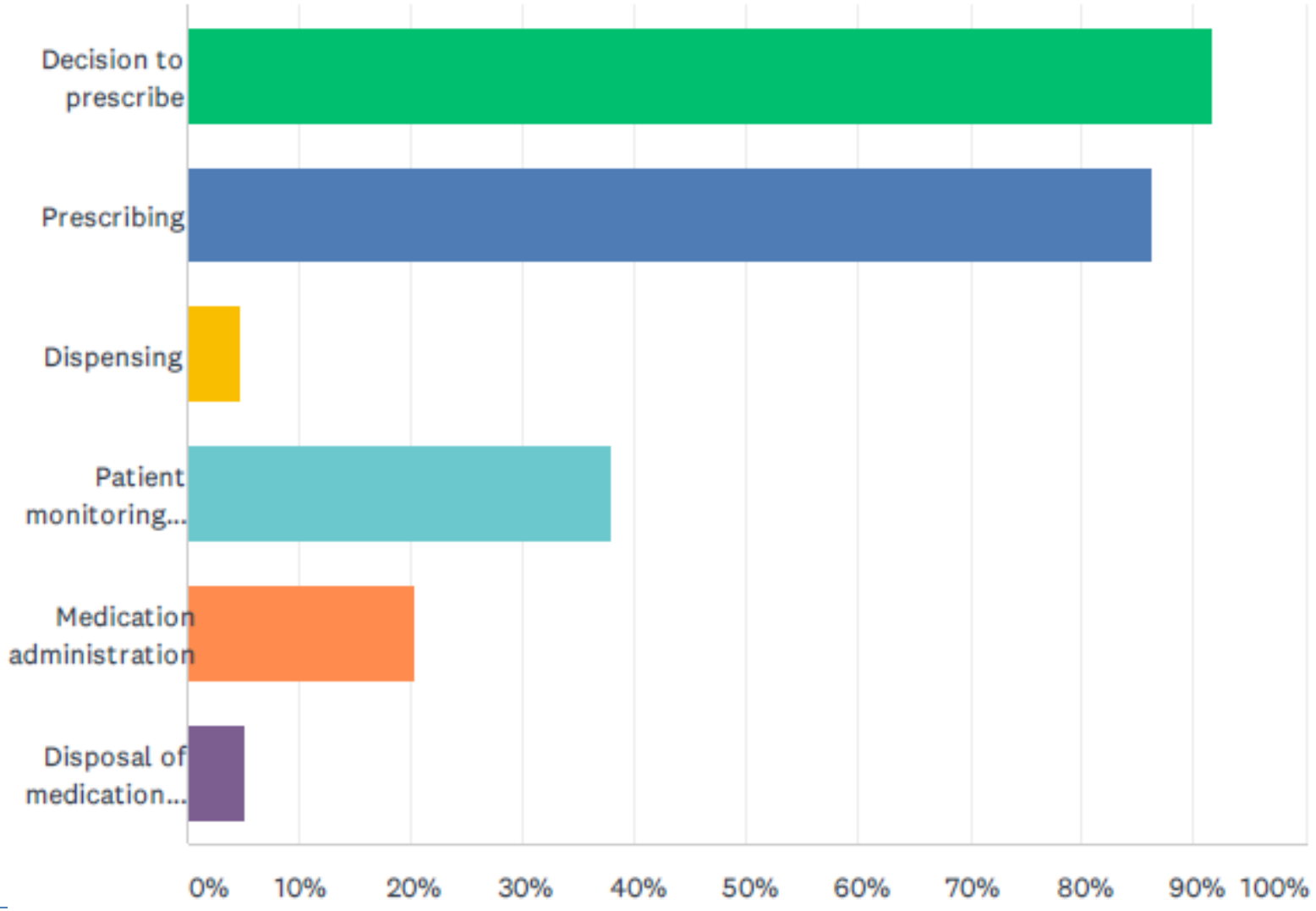
Results: professional roles



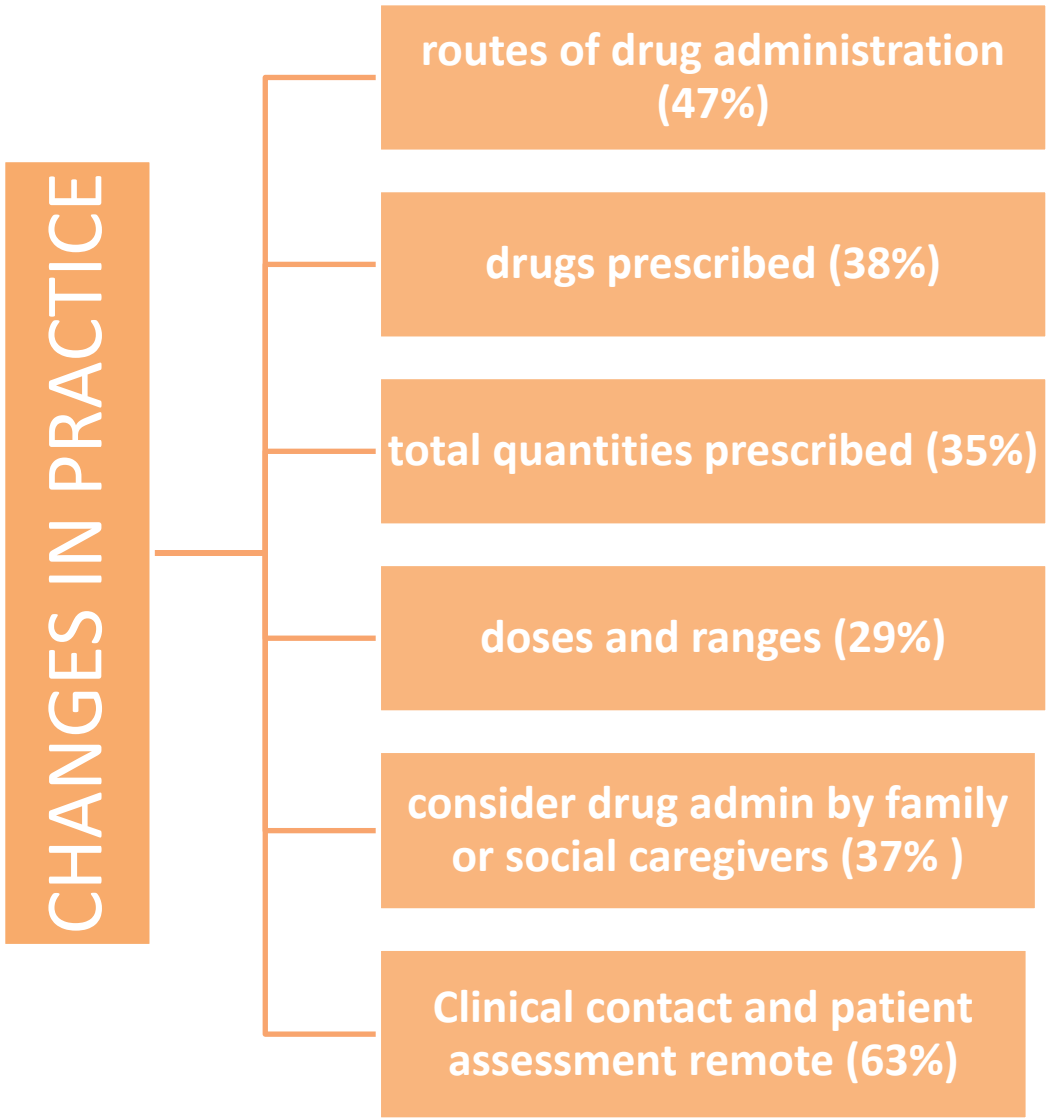
Results: clinical settings



Results: involvement in stages of AP process



Results: changes in AP practice during the 1st wave



Results: open question

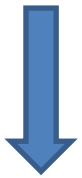
Strong recommendations for **regulatory changes** to permit **drug repurposing** and easier community access

"This is our opportunity to secure legislative change for the establishment of centralised supplies, the ability for clinical staff to have sensible safe boxes and for the return of safe, unused drugs to pharmacies … This is a known and appalling waste that must stop now and be permanent. There has never been a cogent justification."

[#100 CONS]

Discussion

- People at home or in care home are at risk of dying from COVID-19 requiring larger than usual drug doses



current guidance to prescribe drugs in small amounts and close to anticipated death could be problematic

- Wider and more ready community drug access might ease this difficulty but presents legislative and logistical challenges

Conclusions

- The challenges of the COVID-19 pandemic for UK community palliative care has stimulated rapid innovation in AP
- The extent to which these are implemented and their clinical efficacy need further examination
- How much they will persist after the pandemic?

Future work

We planned follow-up interviews

- occured during october 2020, 6 months after the web-based survey

- purposive sample of 16 respondents (total of 28 invited) out of the over 150 who indicated a willingness to do so in the web-based survey.
  - 3 Pharmacists
  - 6 Pall care consultants
  - 3 Pall care nurse speicialist
  - 3 GPs
  - 1 Community nurse

Aim

- To understand, in a more in depth way, what changes, if any, occurred in AP practice 6 months after the 1st covid wave (April 2020) and if those were maintained or went back to how they were before.
- The questions asked in this study are based in the survey.

PRESS RECORD
Verbal consent recorded
Could you start by saying what your role is and how are you involved in AP, what bits of the process do you do

2. MAIN QUESTIONS

a) Can we start by discussing the impact of the COVID-19 pandemic on your personal PEOLC practice and practice in your local area?

b) What was the impact of the pandemic on AP in your personal practice and your local area?

a. *Prescribing*
b. *Route of administration, esp. sublingual / buccal route*
c. *Person administering AP drugs, esp. family / informal carers or social carers*
d. *Use of phone / video to support AP*
e. *Use of syringe drivers*

1 What are your views of changes that took place?

2 To what extent are those changes still in place or has practice returned to how it was pre-pandemic?

3 Looking to the future, how do you see AP developing and changing?

4 What is your number 1 worry concerning AP at the moment, when we don't know what will happen with COVID?

C. CLOSING

Anything else would like to add?

Thanks

Preliminary Results

- There were no notable changes in prescribing
- Lots of preparation for changing routes of administration, but again, in most cases no notable differences 6 months later
- Discussions considering family members with potential to administer AP drugs, but there were always healthcare professionals available to do so
- More use of phone and video, there were pros and cons debated
- The use of syringe drivers did not seem to change, in that criteria used and considerations made for its use, in general, remained the same as before the pandemic

- The biggest worry was supply
- There were not many differences in practice for the future, as things are still working and in most cases, respondents felt the team was reaching the people who needed AP

Preliminary Results

- Positives
  - Video allowed to be present in more meetings without having to travel and with more people present; also allowed to consult patients non critical
  - Breaking down barriers between working groups and within and between institutions, new working relationships forged
  - Reusing drugs in care homes
  - Rethinking reasons for existing processes and making changes to accomodate all involved in patient care
  - Decision making, sense of empowerment and leadership

- Need for safe, standardised practice without compromising individualised patient care – is the development of national guidelines the answer?

So what?

- These studies add to the body of evidence
  - AP is a complex intervention
  - Need for standardisation to reduce variability in practice and improve safety
  - Take into account clinical decision making is dependent in context: resources, culture, geographical region

- Do we need to develop national guidelines? Or/and
- Do we need to develop principles of AP practice to help standardise some processes? E.g.:
  - a single national MAAR Chart
  - Strategies of communication
  - Minimum education/training level to practice anu part of AP

Are we asking the right questions?

THANK YOU!

Please feel free to email us with additional thoughts on today's discussion at:

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9th Feb 2021