Anticipatory prescribing in end-of-life care

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- Nurses’ perceptions of this role

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Abstract
Anticipatory prescriptions are often issued by GPs for patients nearing the end of life, ahead of symptoms they may experience. These prescriptions are often activated by nurses. This article summarises a study investigating nurses' experiences of using anticipatory prescriptions.

There has been widespread introduction of “anticipatory prescribing” in community-based palliative care in the UK (British Medical Association, 2012). This usually means GPs issues a prescription before it is needed, in anticipation of managing symptoms, such as pain and nausea, that are common near the end of a patient’s life.

The process has been complemented by the development of systems to make sure medications can be dispensed out of hours. Nurses in primary care and nursing care homes have a key role in activating anticipatory prescriptions.

This study, funded by Marie Curie Cancer Care, examined community and nursing home nurses' decisions and experiences relating to anticipatory prescriptions and how they work with prescribing doctors and community pharmacists. It complemented an international study of continuous sedation in end-of-life care (Seymour et al, 2014; 2011), which highlighted the importance of, but lack of, evidence about nurses’ roles in this area.

This study aimed to ascertain the roles and experiences of community nurses in end-of-life medication decisions and how these nurses work with others in the healthcare team to implement prescriptions written before the onset of anxiety, delirium and other difficult symptoms among their patients. Undertaken in the Midlands, and Lancaster and South Cumbria, it comprised a literature review, qualitative ethnographic study and a survey of 574 nurses.

Literature review
The full literature review is reported in Wilson and Seymour (2013). We systematically reviewed international literature published since 1990 on nurses’ roles in managing symptoms and distress in the last days of life. Of 140 studies, 26 met our criteria. The following themes emerged:
- The key elements nurses identify as integral to their decision making role;
- How their role is constituted in terms of the use of medications and withdrawal/withholding of treatment;
- Their views and experiences about their role in palliative sedation.

While much existing literature emphasises doctors’ experiences and practices, high-quality end-of-life care depends on good teamwork between nurses and doctors (Xyrichis and Lowton, 2008). Our review shows nurses often feel their contribution to symptom management is neither understood nor valued, although they have Anticipatory prescriptions can help ensure that end of life is pain free for some patients.
considerable responsibility for it. It also shows nurses often face difficulties due to limited knowledge and experience with relevant medications, lack of resources and differentials in professional power between themselves and doctors.

Nurses feel they play an important role in providing information to patients and families, and often liaise with other staff on their behalf. They see a broad approach involving anticipatory planning as essential to high-quality care but are restricted by factors outside their control, including accessing equipment or out-of-hours specialist palliative care (Griggs, 2010).

In relation to nurses’ experiences with symptom control for patients who are dying, a theme of “moral distress” emerged. This comprised a lack of perceived confidence in their skills and knowledge, access to necessary resources, and a sense of not being listened to or having their opinions valued during clinical decision making.

Our review highlights that nurses want to be involved in end-of-life decisions and have the closest insights into patients’ health status and care preferences. They build a bond with patients and families and should be central to decision making.

Qualitative ethnographic study
We spent four weeks with nurses in four care homes and four community teams in two areas of England. Our aim was to observe when prescriptions were written in advance of symptoms, as well as how, when and in what circumstances these were activated. In total, 83 observation periods were undertaken and 72 interviews completed with: district nurses (n=27), specialist palliative care nurses (n=18), nursing home nurses (n=16), doctors (n=8) and pharmacists (n=3).

Participants gave written consent at the start and verbal consent was gained from those in the fields of observation. Patients and family carers were given information about the study and asked to verbally consent to, or opt out of, aspects of their care included in observations.

In line with a study on similar issues (Faull et al, 2013), we found anticipatory prescribing is a process, not an event. Nurses play a key role in initiating this by prompting GPs when they realise patients are nearing the end of life. Building on Faull et al (2013) we identified four phases of anticipatory prescribing: initiation, writing, dispensing, and administering.

Key challenges nurses raised were:
» Identifying when patients entered the dying phase;
» Working and forming relationships with GPs to enable appropriate initiation;
» Writing a correct, valid anticipatory prescription.

Some GPs lacked knowledge of the medications used and, as such, also the confidence to prescribe them. Once an anticipatory prescription was written, nurses met with dispensing challenges: some pharmacies had limited stock or could not deliver medications. This was especially difficult out of hours.

Once medications were correctly prescribed and dispensed, nurses highlighted four things that must be met before administering an anticipatory prescription:
» Symptoms that were both irreversible and due to entry into the dying phase;
» Inability to take oral medication;
» Patient consent where possible;
» Decisions made independently of influence from relatives.

By using anticipatory prescriptions, nurses tried to ensure patients were “comfortable and settled” by providing gradual symptom relief at the lowest dose possible. A key driver was avoiding hospital admission or medical call-out. Nurses sought to “do it by the book”, adhering strictly to local prescribing policies and guidelines. Some worried about distinguishing between pain and agitation or perhaps hastening death. We observed a potential for some symptoms to be under- or untreated as a result of these.

Overall, nurses sought to use caution and consideration when administering anticipatory prescriptions, along with critical thinking and clinical skills and knowledge to ensure medications were used in an appropriate and timely manner. However, some lacked confidence in their skills and knowledge; many reported working in pairs or seeking support. Those with least experience or support experienced stress when administering anticipatory prescriptions.

This is reported in Wilson et al (2014).

Survey
Nurses were surveyed across the two areas examined in the ethnographic phase. We developed the survey questionnaire with help from two clinical advisers, informed by findings from the literature view and ethnographic study. A draft was piloted with five community nurses, whose feedback was used to refine the questionnaire.

Initially, 500 district/community nurses from each area were chosen at random, as well as all specialist palliative care nurses, Macmillan and Marie Curie nurses and managers, and matrons of care homes/nursing homes. To exclude individuals unlikely to be involved in caring for an adult who had died at home or in a care home, nurses’ job and institutional titles were inspected. Between February and May 2013 the survey was posted to the final sample of 1,739; 818 had moved to other jobs, leaving a sample of 1,558.

The overall response rate was 37% (n=574). Group respondents rates were: community nurses (n=192, 25%), care home nurses (n=231, 50%), specialist palliative care nurses (n=151, 48%). Of these, n=481 (84%) reported caring for at least one person who had died in the past year, with 98% of those saying an anticipatory prescription was in place for at least one patient. Survey findings mirrored issues reported in the ethnographic phase; the survey and other qualitative data should be published in due course.

Summary
The study shows nurses take a leading role in administering anticipatory medications. They use consideration and caution but some feel burdened due to the nature of the decisions, and would benefit from more support. Education, training and experience increase confidence, and support of nurses’ practice should be central to efforts to improve palliative care in the community.

References


