Power Relations and Prescribing

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PhD Studies: Quality and Continuity of Medication Management when People with Dementia move between Care Home and Hospital

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Overview

Introduction

- Overview of Study
- Knowledge is Power
- Types of Knowledge

Professional vs Patient/Family

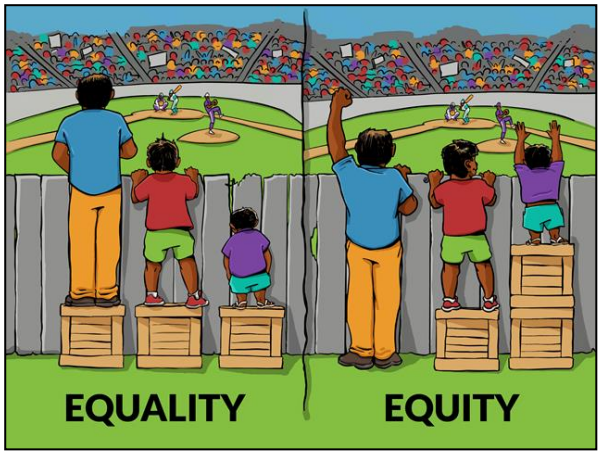
- Paternalism
- Power Imbalance = Knowledge Gap
- Shared Decision Making and Evidence Based Medicine
- Supporting a Person-Centred Approach
- SDM and Deprescribing
- NHS 10 Year Plan: Personalised Care

Power in Professional Relationships

- Impact on Integration and Personalised Care

Considerations for Practice

GARY WATERS/IKON/GETTY IMAGES

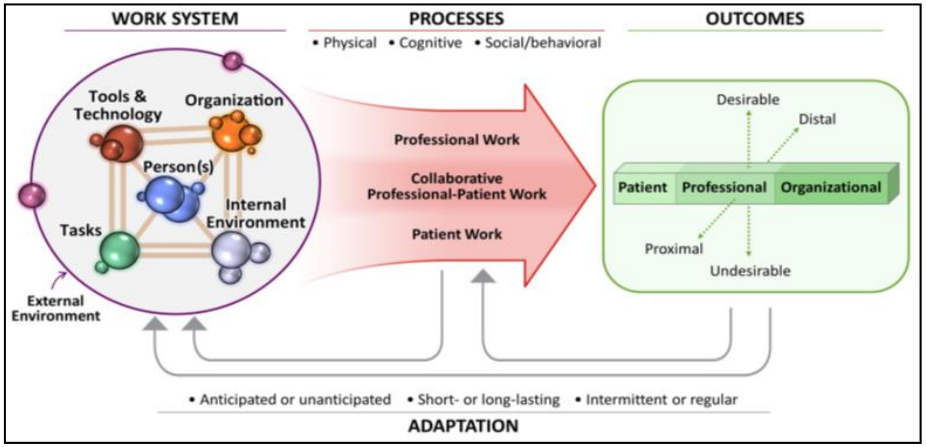


Interaction Institute for Social Change | Artist: Angus Maguire.

PhD Study

Aim: Explore the factors which influence the quality and continuity of medication management for people with dementia when they move between the care home and hospital setting

IOM, 2001



SEIPS 2.0: Holden et al, 2013

Key themes…..

Policy practice gap; **Power and Relationships**; Organisational constraints

"...scientia potentia est."

Sir Francis Bacon, 1597

(Meditationes Sacrae [1597; Works 14.95; 79]).

Is all 'knowledge' power?

?Type of Knowledge = Power

- Power appeared to be associated with having (specialist) ‘medical/ clinical’ knowledge i.e. healthcare professionals.
- ?Impact on person-centred approach

Leads to…

- Paternalism (barrier to shared decision making)
- Affected staff relationships within and across boundaries (barrier to integration)

NB ‘Power of the system’

Paternalism

Professional (↑ Power)

The paternalistic model of the doctor (staff)-patient relationship, places the staff member in position of 'patient guardian'; articulating and implementing what is best for the patient, with limited patient participation' *(Cole et al, 2017; Emanuel & Emanuel, 1992).*

"We do everything…they [residents/families] don't have a particular role …". [CH Nurse]

"… if the patient has dementia I don't… I don't think we let them or the family know [if medication is changed] probably as reliably as we should…" [Hospital Doctor].

"…we make multiple changes and we rationalise drug charts a lot on here to get rid of the polypharmacy issues. Some patients, the ones with better cognition, we will say 'we're going to change your blood pressure tablets' or do this or do that, but a lot like I say of our patients wither temporarily or permanently can't compute that information" [Hospital Nurse]

Patient (Advocate) (↓ Power)

Assume 'passive' role... Perceive own knowledge as limited (rather than different).

Trust and respect staff expertise and less willing to challenge professional authority.

"I've been taking them for years and, um, I just take them and that's it…I do as I'm told". [Person with dementia]

Well, I wouldn't question them, you know, because they know what they're doing." [Person with dementia]

"Well I would [like to be involved], but not that I would understand it [medication information]… they might put it down in Latin, I wouldn't know… they're just white tablets to me" [Person with dementia]

"… I'm not a chemist or a doctor. The chemicals involved just go straight over my head…But I'd like to know if they do change" [Relative]

Power Imbalance = Knowledge Gap

- **Needs values and preferences not always acknowledged in initial prescribing decision**
  - When is this ok? When is this NOT ok? Staff and families mention **'big'** or **'high risk'** decisions ??
  - Need for **training** e.g. involving people with communication/ cognition difficulties.
  - Importance of **review** in Primary Care
  - Use of **other people** and **documentation/ records** to inform prescribing (family; social care)

> *"I think they [hospital] tried giving it to her normally, but she just wouldn't take them…." [Family member]*
>
> *"…we do sometimes get patients coming in and the nurses will say 'we need liquids for everything', because I think they think oh no they are not going to swallow the tablets, but if you've got that bit of info prompting you might be able to use the tablets". [Pharmacist]*

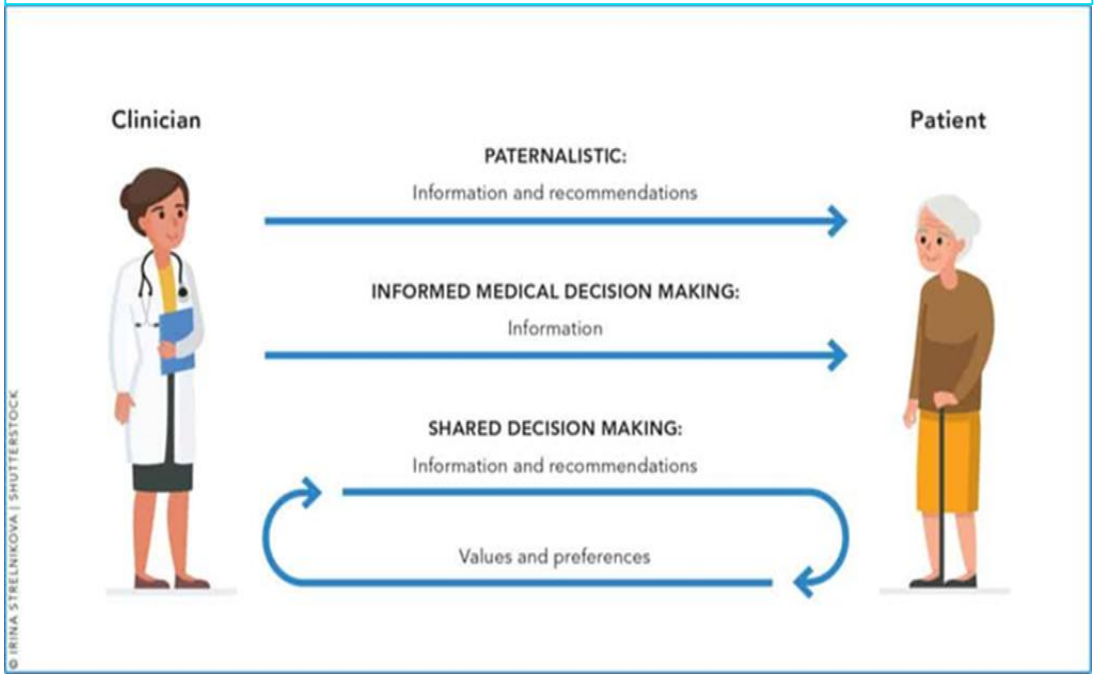
- **Many people with dementia (and families) did want to be involved but they didn't appear to know how**
  - Worried they **didn't 'know enough'** about their medicines for 'meaningful' involvement…
  - Many people with dementia **keen to share experiences/challenges** associated with their current medication e.g. troublesome side effects; too many tablets; manual dexterity and swallowing difficulties.
  - **Didn't want to 'challenge authority**'- 'Battle on', rather than 'make a fuss':

> *"…as I say, I think the powers that be would say, well you should be taking such and such a medicine... But I do remark sometimes that, er, has this got acid in it? …that does bother me, they tend to taste of acid and I don't know which one it is, but I find that sometimes it does make me sick." [Person with dementia]*
>
> *"…sometimes it goes down uncomfortable and they might stick another tablet in there… They do, um, they keep shoving pills in me, you know, 'have it with a drink of water' like." [Person with dementia]*

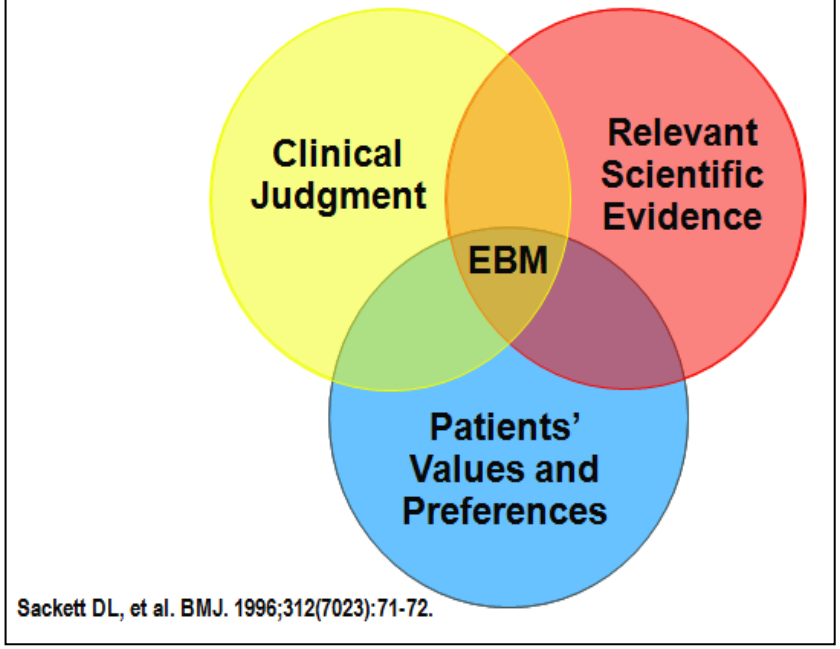
Shared Decision Making & Evidence Based Medicine

"Shared decision making (SDM)…brings together the individual's expertise about themselves and what is important to them together with the clinician's knowledge about the benefits and risks of the options. This means that lay expertise is given the same value as clinical expertise" [NHS website]

Shared Decision Making



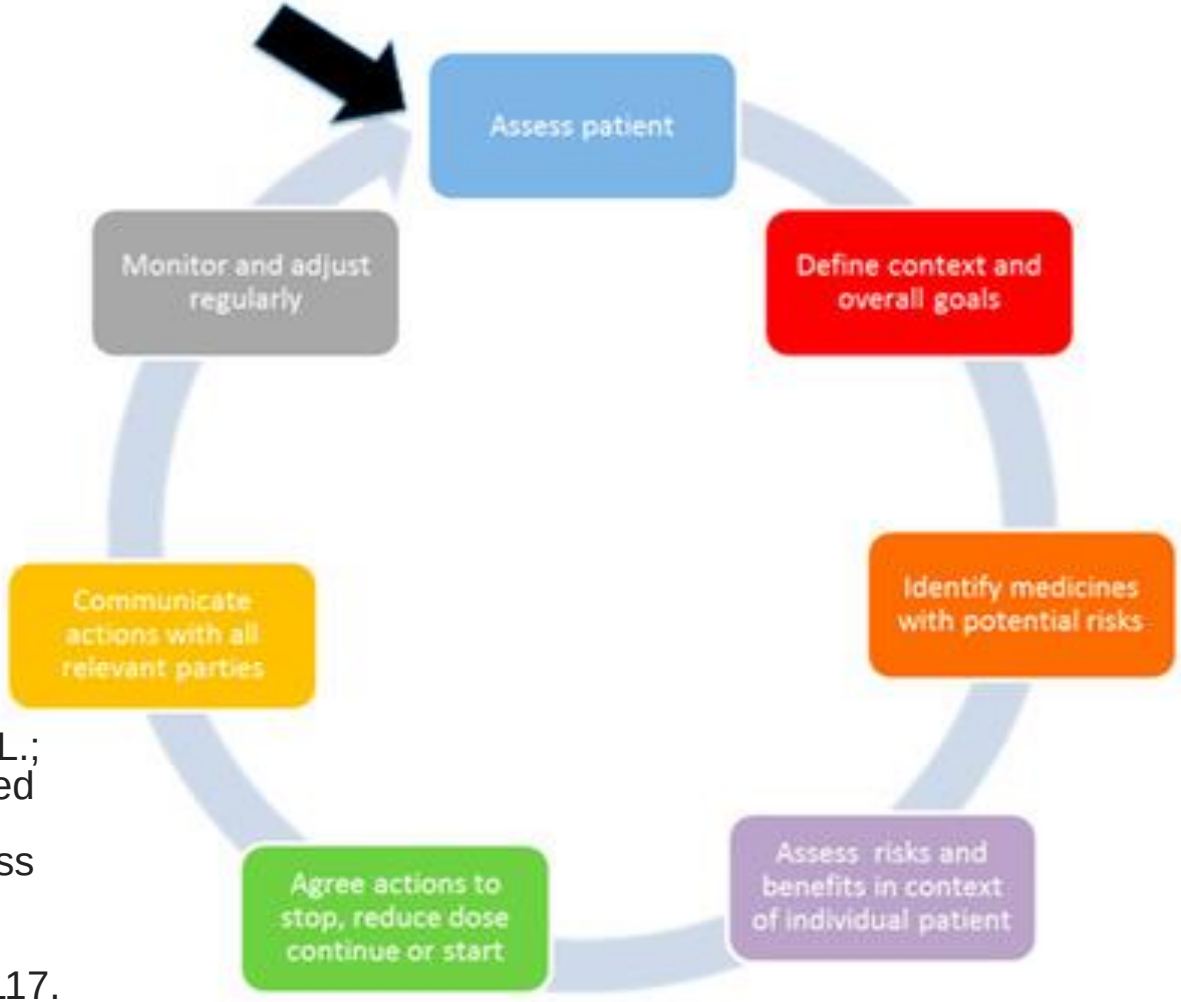
Evidence Based Medicine



Medicines Optimisation guideline [NICE, 2015]: *"Shared decision-making is an essential part of evidence-based medicine, seeking to use the best available evidence to guide decisions about the care of the individual patient, taking into account their needs, preferences and values"* (Greenhalgh et al. 2014; Sackett et al. 1996)

SDM and Deprescribing

A patient-centred approach to polypharmacy



Eur. J. Hosp. Pharm. **2016**, *23*, 113-117.

Personalised Care Operating Model

NHS England

WHOLE POPULATION
When someone's health status changes

30% of POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

Shared Decision Making

People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action based on their personal preferences and, where relevant, utilising legal rights to choice.

(All tiers)

Personalised Care and Support Planning

People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing

Review

A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

COMMISSIONING, CONTRACTING AND FINANCE ENABLER

WORKFORCE ENABLER

Optimal Medical Pathway

Social Prescribing and Community-based Support

Enables all local agencies to refer people to a 'link worker' to connect them into community-based support, building on what matters to the person, and making the most of community and informal support.

(All tiers)

Supported Self Management

Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education.

(Targeted and Specialist)

Personal Health Budgets and Integrated Personal Budgets

An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs.

(Initially Specialist)

DIGITAL ENABLER

Power and Relationships: Integrated Care

Staff Relationships: Breaking down Barriers/ 'Them and Us'

Care Home: "*There is a bit, there is a bit of a barrier, definitely there's a bit of a barrier…they think nursing homes don't know what they're talking about…"*

Hospital*:"I think it would be nice for the hospital and the care homes to be a lot more integrated and maybe a bit more friendly to each other. I think sometimes we feel as though it's them and us, they are obstructive to us, we're obstructive to them. [Nurse*

- Power imbalance between staff poses a potential barrier to integration and the quality and continuity of medication management.
- Support evolving roles
  - Integration fund: Pharmacists prescribing/reviewing medicines in care homes and GP practices
  - Care Home Staff: Medication Reconciliation

NHS FYFV: *"The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need."*

Supporting a Person-Centred Approach

- Consider how **current policies; processes and practice support staff** to implement a person centred approacl
  - Integrated Care
  - Clarify what information is useful in supporting a person-centred approach to medication management (across settings)
  - Identify boundaries…are there situations when people should ALWAYS be involved?
  - Consider the role of documentation- clearly record/ document discussions

- Consider how **current systems support staff** to implement a person-centred approach.
  - ?System re-design- Personalised approach limited by current system constraints:
    - E.g: Limited (trained) staff; Limited time; System demands; Competing Priorities (Safety vs Efficiency vs PCC); Training needs; Outcomes and Incentives

- Consider how **current relationships impact on the delivery** of a person centred approach.
  - Empower people- help people to understand expectations and why their contribution is important (people (patients); family; social care professionals)
  - Power dynamics and relationships between other staff/ parts of the system may also affect communication of information which supports and enables needs and preferences of patients to be recognised
  - Encourage involvement and contribution from the person and those 'who know the person'- have they expressed any wishes regarding treatment preferences?
  - Challenge 'power imbalance': 'Traditional' attitudes/ Historical relationships (social vs health; primary vs secondary care.

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Summary

- Be aware.
- Be Proactive… challenge Power Imbalance to optimise patient care at ALL LEVELS.
- Develop policy recommendations which support person- centred approach (across sectors where necessary) for organisational policy AND provide practical support/ guidance/ tools which support staff to implement.
- Awareness of barriers and facilitators of SDM.
- Share practice; discuss training needs and provide support/ guidance for staff (especially re people with more complex needs such as people with dementia).
- Documentation of needs and preferences re decision making (level of involvement; who involved e.g. family). Clarify roles and expectations i.e. no medical expertise required!
- Documentation of needs and preferences re medication which may influence future prescribing decisions/ administration of medication etc.
- 'Systems thinking approach'- understand the level of patient involvement in other parts of the system. Understand how you can support them and they can support you to provide best patient care.

NICE National Institute for Health and Care Excellence

Shared decision making
In development [GID-NG10120]
Expected publication date: 14 April 2021….