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Anticipatory prescribing

This article, written by **Ruth McChesney** and **Patricia McClunie-Trust**, introduces anticipatory prescribing as a response to community palliative and end-of-life-care challenges in New Zealand. It then proposes an anticipatory prescribing guideline derived from a realist review and outlines implementation strategies

In New Zealand, the pursuit of dignified end-of-life care aligns with the belief that individuals facing life-limiting conditions should receive compassionate, culturally responsive care tailored to their preferences, all within the comfort of their homes.

The quest for "living well and dying well" is surrounded by substantial challenges in New Zealand, where access and equity pose significant hurdles to palliative and end-of-life care. Despite two decades of policies and funding initiatives, the reality often falls short. There is a gap between people's desire to spend their last days at home and the prevailing norm of institutional settings, with hospital admissions and emergency care dominating, especially for older New Zealanders.

Dying in contemporary Western societies presents unique challenges marked by a collective deskillment in caring for loved ones in their final moments. The lack of exposure to expected deaths at home leaves generations of people uncertain about the appropriate course of action. Palliative care, typically initiated within general practice teams, also faces challenges, particularly in bridging incongruities between primary care and the unpredictable nature of disease trajectories.

Patients with life-limiting conditions, often contending multiple long-term illnesses, add layers of complexity. Diseases such as dementia or advanced long-term conditions (eg, organ failure) have less predictable trajectories than that of cancer, which makes planning and providing patient-centred care more challenging. The anticipated tripling of non-cancer deaths within the next 15 years, driven by an ageing population, exacerbates these challenges amid healthcare resource shortages, painting a concerning outlook for end-of-life care in New Zealand.

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Beacon of hope

In the face of these challenges and the frequently turbulent experiences that unfold for patients and carers, anticipatory prescribing emerges as a beacon of hope within the community context. Anticipatory prescribing strives to extend palliative care support, placing patients and their families at the centre of care, supported by primary caregivers and GPs.

The Western Bay of Plenty sets an example with its "Just in Case" plan initiative (portal.wboppho.org.nz/just-in-case-resources). Collaboratively crafted by GPs and nurse practitioners, these individualised plans incorporate anticipatory prescribing as a proactive measure. Involving Hato Hone St John ambulance personnel who are trained to use these plans creates the potential for seamless, patient-centred, responsive care at home.

While New Zealand's palliative care definition and strategy uphold holistic and culturally responsive principles, translating them into practice remains a challenge. This article advocates for a standardised guideline on anticipatory prescribing, drawing from research-based knowledge and best practices. We propose initiating this transformative journey in the Western Bay of Plenty, where the Just in Case plan has been implemented.

Do you need to read this article?

Try this quiz

1. **Anticipatory prescribing emphasises the preference for culturally responsive care in institutional settings. True/False**
2. **Expertise is strongly associated with anticipatory prescribing. True/False**
3. **In anticipatory prescribing, the priority is less about ensuring a "good death" and more about avoiding burden on colleagues during non-office hours. True/False**
4. **Identifying palliative needs early is a premise for anticipatory prescribing. True/False**

Answers on page 34

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Realist review provides insights into safe and effective practices

While the clinical guideline for anticipatory prescribing proposed in this article places the patient in the centre, it is also informed by research. Our realist review (McChesney and McClunie-Trust, 2021) identified several factors that shape the implementation of anticipatory prescribing in the context of community palliative and end-of-life care. The review findings were organised into three overarching themes: expertise, teamwork and prioritisation. The expertise theme was further delineated into two subthemes: "knowing when to prescribe" and "knowing how to prescribe".[1] Subsequent explanations on culture, equity and patient voice delve into a more detailed exploration of these themes.

Expertise

The strongest influence on anticipatory prescribing is the expertise of designated prescribers. Education and experience prompt prescribers to undertake anticipatory prescribing before it is too late. Having an awareness of palliative care guidance, pathways and resources also encourages anticipatory prescribing to take place.

The subtheme of knowing when to prescribe reflects a skill in getting the timing of anticipatory prescribing right. Ensuring timely symptom control can be given to those patients with less predictable illness trajectories requires insight into the preparation needed and skilful conversations to take place with the patient and whānau/family. In contrast, conditions with more predictable trajectories and deterioration patterns can often be managed with standard prescribing. The figure below outlines the timing considerations for initiating prescribing in relation to different disease trajectories.

While clinician expertise undeniably contributes to the wellbeing of patients with palliative and end-of-life-care needs, elevating expertise to be a central factor in successful initiation of the anticipatory prescribing process could bring about even greater benefits for these patients. Building expertise starts by putting education and pathway resources in easy reach and focus of the primary provider team.

Teamwork

Teamwork and communication are instrumental in the anticipatory prescribing context. Effective and responsive communication is needed for the prescriber to build links with other professionals involved. Telephone and video consulting can increase access to, and responsiveness of, GPs for patients and interdisciplinary team members alike. Telehealth is a medium that was accelerated by the COVID-19 pandemic but which may well continue and be developed further through digital innovation.

Health professionals involved in anticipatory prescribing need to understand the differing roles and responsibilities of the interdisciplinary team – that is, between the GPs, NPs, pharmacists, paramedics and community nurses. Since the anticipatory prescribing intervention requires accuracy at the stages of prescribing, dispensing, administration and assessment of indication, there is an underlying need for robust shared understandings and effective communication. Each stage and each discipline involved relies on another.

> "As improvements are pursued in palliative and end-of-life care, there is an opportunity to make equity a prominent thread in the anticipatory prescribing context"

Building and maintaining interprofessional trust enables prescribers to delegate care to their interdisciplinary colleagues while retaining responsibility. Facilitators of interdisciplinary trust include prescribers being receptive to other professionals' input and having interdisciplinary education sessions, case reviews, shared electronic health records and good conversations. These conversations are ideally face to face, but where feasible circumstances do not allow, they can take place remotely.

Where interprofessional trust works well, GPs rely on other team members to act as their eyes and ears, and to advocate for anticipatory prescribing when the need is indicated. An adequate link between the prescriber and patient is also necessary to facilitate the anticipatory prescribing process. The interdisciplinary team can promote this to occur.

Prioritisation

The prioritisation theme pertains to clinicians recognising the importance of a "good death" and undertaking anticipatory prescribing as their contribution towards supporting this. At times, anticipatory prescribing is put in place to safeguard the patient from crisis, when the patient is still stable, much like an insurance policy. When this early approach is not taken, it can become too late to intervene, particularly in the deterioration of non-cancer conditions.

Additionally, some GPs wish to prevent the responsibility of care defaulting to their out-of-hours colleagues, where the management of situations can be more challenging than for those who have continuity of care. Foundational to this is the proactive mindset and risk-versus-benefit thinking around the uncertainty of the context, and putting the patient's needs at the centre.

Whether heightened demand on the health system is perceived, expected or actual, this can lead to prioritisation in anticipatory prescribing for community palliative and end-of-life-care needs. During a 12-month period during the COVID-19 pandemic in the UK, deaths at home rose by 41 per cent. Deaths at home were enabled by anticipatory prescribing and through inviting family and informal carers to manage end-of-life medications in the home. Although stressful and disruptive in the context of widespread community COVID-19, this ability to meet population needs demonstrates the potential scope to prioritise this approach to care in New Zealand.

Gaps: Culture and equity

The studies in the anticipatory prescribing review lacked comprehensive exploration of the values and cultural considerations specific to individuals and populations. A brief general remark was made on inequalities facing ethnic groups in the UK but without adding an understanding of these inequalities.[1]

Equitable access to healthcare and equitable outcomes in health have become a global pursuit to the extent that equity is now considered intrinsic to quality. While other countries may be at different stages of narrowing health equity gaps, gains are being made in New Zealand and it remains a key priority, particularly for Māori. As improvements are pursued in palliative and end-of-life care, there is an opportunity to make equity a prominent thread in the anticipatory prescribing context, and to support clinicians to take meaningful actions towards achieving equity.

Patient voice

Listening to the patient and family voice is important in the process of anticipatory prescribing, to recognise the partnership that takes place and ensure the focus of care is on the patient and their support unit.

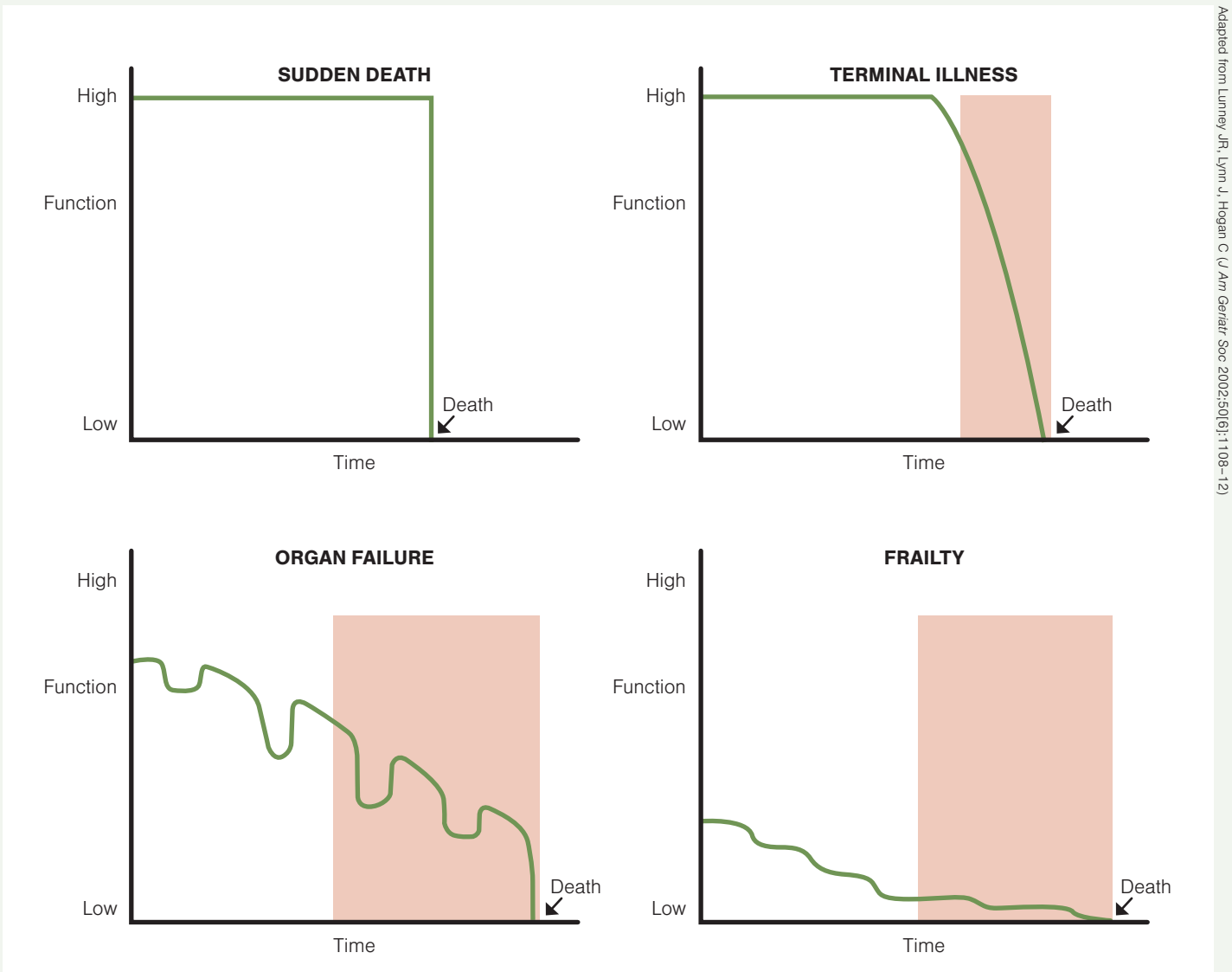
In a recent UK study, Kristian Pollock and colleagues interviewed a small sample of bereaved family members where anticipatory medications had been used. One strong theme was that anticipatory prescribing had not been clearly communicated to or with the patient and family members. This reflected not only the doctors involved but also the pharmacists and nurses early in the process. Some discomfort was also felt by these patients and family members in storing the medications at home.[2]

Nevertheless, with effective communication (discussed in more detail later), there may be an opportunity to shift this perception and provide guidance on practical approaches to managing discomfort levels.

In two examples from the above study, where the desired purpose of anticipatory prescribing was achieved, the family members testified to valuing the availability and administration of the medications, viewing it to be a positive response to the needs of end-of-life care.[2]

Evidence-based recommendations

- Prioritise improved serious illness conversation skills. Consider training tailored to general practice teams around the *Serious Illness Conversation Guide* (myacp.org.nz/serious-illness-conversations). Promote earlier conversations in a patient's serious health journey, which include discussions around anticipatory prescribing.
- Address the lack of palliative care education to primary palliative care providers. Consider a co-design improvement project. Consider introducing minimum requirements.
- Further develop cultural responsiveness and increase awareness of whānau ora approaches (eg, te ao Māori framework).
- Develop greater potential for interdisciplinary teams to meet palliative care needs. Promote shared education sessions and improve understanding between professions – doctors, nurses, paramedics and allied health. Consider adding interprofessional competencies into the Health Practitioners Competence Assurance Act 2003.
- Aggregate and disseminate data that increase visibility of the needs and inequities to be addressed. Ensure equity for Māori is prioritised. Measure and celebrate success.



When to initiate prescribing (red box) in relation to the illness trajectory

Adapted from Lunney JR, Lynn J, Hogan C (*J Am Geriatr Soc* 2002;50[6]:1108–12)

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References: 1. Loh CH *et al. Ann Am Thorac Soc* 2017; 14: 1305-11. 2. Ghosh S *et al. Int J Chron Obstruct Pulmon Dis* 2019; 14: 585-95. 3. National Asthma Council Australia. Inhaler technique for people with asthma or COPD. Information paper for health professionals 2018. Available from www.nationalasthma.org.au. Accessed November 2021. 4. SPIOLTO Respimat Consumer Medicine Information Sept 2021. 5. Hodder R, Price D. *Int J COPD* 2009; 4: 381-90. 6. Schürmann W *et al. Treat Respir Med* 2005;4:53–61. 7. Kardos P *et al. Eur Respir J* 2005; 26(Suppl 49): 338s. 8. Wachtel H *et al. Pulm Ther* 2017; 3(1): 19-30. 9. Dalby RN *et al. Med Devices* (Auck) 2011:4:145–55.

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Developing the guideline: When, what, why, where and how

Ramon Oliveti

Anticipatory prescribing provides a beacon of hope to the challenges of community palliative and end-of-life care

TABLE 1. **Elements of the guideline and supporting tools**

Element	Explanation	Supporting documents or tools
When	Prescribed in advance for timely access, day or night	• RNZCGP Foundation Standard indicator 5.3 (tinyurl.com/Foundation-5-3) • *Serious Illness Conversation Guide* (myacp.org.nz/serious-illness-conversations) • Supportive and Palliative Care Indicators Tool (spict.org.uk) • *The Gold Standards Framework Proactive Identification Guidance* (tinyurl.com/GSF-PIG) • *Te Ara Whakapiri: Principles and guidance for the last days of life* (tinyurl.com/te-ara-whakapiri)
What	Access to medications to address typical symptoms	• *Mauri Mate: A Māori Palliative Care Framework for Hospices* (hospice.org.nz/mauri-mate) • *New Zealand Health Strategy* (health.govt.nz/publication/new-zealand-health-strategy) • *Te Ara Whakapiri: Principles and guidance for the last days of life*
Why	To relieve distressing symptoms	• Advance Care Planning (myacp.org.nz) • *Code of Ethics for the New Zealand Medical Profession* • *The New Zealand Palliative Care Strategy* (tinyurl.com/NZPCS)
Where	Where needed, typically at home, in line with patient wishes	• *New Zealand Health Strategy*
How	Through an interdisciplinary team approach, involving whānau/family and an IT clinical portal	• *New Zealand Health Strategy* • *Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand* (tinyurl.com/RC-framework)

Life-limiting conditions can confront people with many challenges, up to and including death and dying. Dying affects all people, no matter who they are and what background they are from. Fair and universal access to humane and dignified support and services needs to be available. Enabling a way to provide timely access to medications for patients with distressing symptoms, where and when they need them, is a part of humane and dignified support and underpins the purpose of this proposed guideline.

Mortality and morbidity outcomes

Defining effectiveness in the context of a palliative and end-of-life-care guideline differs from a guideline with a curative model. Rather than reducing mortality, this guideline has a focus on improving the quality of life until death, and the quality of dying and death.

Reducing morbidity is as important in the palliative context as in any guideline. Interventions in a palliative care context need to reflect the desired outcomes of the individual and can include choices around antibiotics, transport to hospital and goals of care. More broadly, morbidity can include any health outcome that people experience and care about – physically or mentally.

This guideline promotes practices that support what individuals care about and are in their best interests. These can vary between patients because the guideline is patient-focused, but it is most effective when needs are identified and discussed early to enable informed choice.

Other outcome measures

Most clinical guidelines focus on the management of a single condition. The main weakness of this is the failure to address the impact of comorbid conditions, which are increasingly prevalent. The criteria for applying the anticipatory prescribing guideline are not condition specific, but rather, based on prognosis. It is applicable to a wide range of life-limiting conditions.

Since accurately predicting a time frame until death can be incredibly challenging, the guideline promotes the use of verified tools such as the Supportive and Palliative Care Indicators Tool (SPICT; spict.org.uk) or *The Gold Standards Framework Proactive Identification Guidance* (*GSF PIG*; tinyurl.com/GSF-PIG). The figure (previous page) may also be helpful. These tools can be used in conjunction with the "surprise question" approach – that is, would you be surprised if the patient were to die in the next year (or the next few months, weeks, days)?

Introducing the guideline

The draft guideline for "Anticipatory prescribing in community palliative and end-of-life care" is presented on the next page. It presents a purpose, a criteria framework, a model of care, appropriate patient cohorts to consider, health professionals who can be involved, prescribing and dispensing considerations, and the sharing and management of information and care. Additionally, two patient scenarios are provided for context.

Resources that support the guideline

The guideline aims to facilitate prompt access to medications for patients experiencing distressing symptoms when and where they require them the most. This statement of purpose implies the when, what, why, where and how of the anticipatory prescribing intervention (Table 1).

With respect to the timing (*when*), medications must be prescribed in advance of the immediate need so they can be available in a timely way. To define *what* the purpose is, it is to provide medications to manage distressing symptoms. Relieving this distress, especially where harm can be predicted, represents the *why*. *Where* the patient is, generally being their usual place of residence, and in line with their wishes, demonstrates responsive patient-focused care. This is enabled (*how*) through an interdisciplinary team who are available to respond at any time and who can involve whānau/family in the process.

The elements outlined in the guideline are closely linked with the themes of key New Zealand documents and other clinical tools, and consistent with the strategic aims of the *New Zealand Health Strategy, The New Zealand Palliative Care Strategy* and several more (Table 1). The current healthcare reforms have the potential to further influence and shape these connections.

Developing high-quality, high-value, sustainable, equitable and patient-focused care are common aims of the strategies reflected in the practice guideline. Growing bodies of evidence contribute to clinical tools being developed, such as the SPICT and *GSF PIG*. These tools support early identification of palliative needs, which is linked with high-quality palliative care and improved patient experience. Identifying palliative needs early is a premise for prescribing anticipatory medications.

To ensure patients and whānau/family are represented in the process of when to prescribe, conversations around shared care approaches should be taking place, such as those in the *Serious Illness Conversation Guide*. This communication tool serves as a guide in the process of exploring a patient's understanding of their illness, identifying their priorities and addressing concerns about future deteriorations in their health. It facilitates a thoughtful exploration before clinicians make recommendations, taking into account the patient's values and the available interventions. Anticipatory prescribing may be discussed as a recommendation, and more than once if it is introduced early in the patient's journey.

This communication approach is likely to alleviate some of the reported confusion among patients regarding the purpose of anticipatory medications.[2]

Connecting with patients

Setting up conversations can be key to establishing connections and providing the opportunity for patients to talk about their life-limiting conditions and dying. Doing so early will invite space for communication and trust to develop, even if the patient is not initially conversation ready.

Embracing the value of whakawhanaungatanga may allow vulnerable situations to feel safe and permitted, hinging on relational trust, shared connections, and understandings of whakapapa (genealogy/connections) and manaakitanga (hospitality/care). The Hui Process promotes these principles within a simple framework for building engagement, particularly for Māori.[3]

Respect, compassion and openness about uncertainty are all important elements of the conversation. Staying curious about what is most important to patients and their whānau will minimise the risk of clinicians making assumptions.

In general, GPs may be best placed to have these conversations and should serve as the primary provider with ongoing continuity of care. However, if GP involvement is limited for whatever reason, serious illness conversations and anticipatory prescribing may be initiated by another health professional, such as a hospital clinician, specialist palliative care provider or NP. If this provider does not have continuity of care, a review of the conversation, plan and anticipatory prescribing should be requested by the patient's GP so they can assume oversight of the treatment plan moving forward.

The National Institute for Health and Care Excellence identified multiple studies that reveal patients want to feel involved in discussing their treatment and palliative care options with health professionals, not merely have a recommendation made to them, even if the recommendation is a good one. Taking a broad approach initially, to inform patients and family members about the available treatment options and what to expect, equips them to make the necessary decisions later.

This supports the notion that a discussion involving anticipatory prescribing should ideally take place more than once and in the context of what symptoms the patient could expect, rather than making the jump to a paternalistic recommendation. This approach allows those not ready to plan end-of-life care some more time, while others who are ready to talk can do so and achieve a sense of control and reassurance about their symptom needs.

While conversations would ideally be initiated by the patient and whānau, research indicates that consumers find initiating serious illness conversations difficult and want others to do so. In light of this, acquiring skills such as those provided by the *Serious Illness Conversation Guide* is recommended, as it offers a structured content flow and patient-tested language.

In the context of the part-charge fee-for-service model in general practice, where patients may be attending for another need, holding these conversations could be challenging for GPs. However, creating opportunities is crucial. Introducing the topic during a consultation and subsequently inviting the patient and key family members for an extended appointment could be an appropriate approach.

Quiz answers

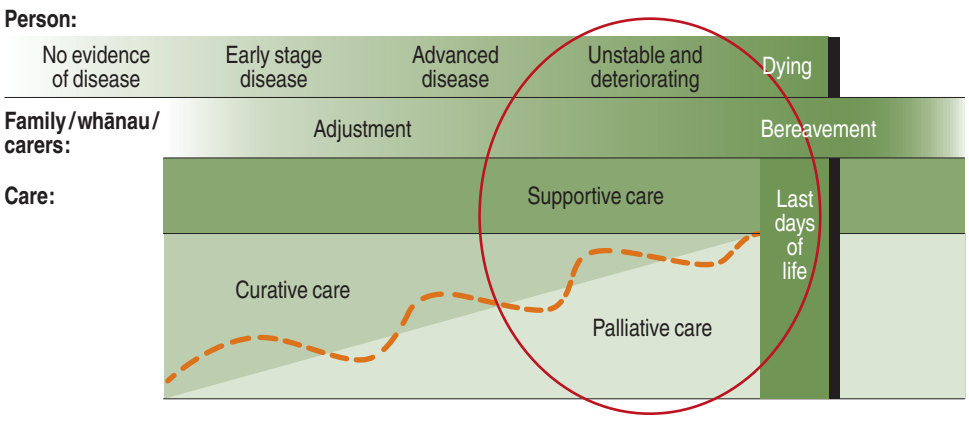
1. False **2.** True **3.** False **4.** True

Anticipatory prescribing for community palliative and end-of-life care

Draft guideline for Western Bay of Plenty

Purpose
To enable timely access to medications for patients with distressing symptoms where and when they need them most.

Who is it for?
- Those with advanced life-limiting conditions with a prognosis <12 months.
- Could be receiving supportive care only or some active care (while it still offers some benefit) – see figure below.
- Those at risk of acute deterioration.



Anticipatory prescribing (circle) during palliative and end-of-life care

Model
- The patient and whānau/family unit should be a key player in care decisions.
- The GP partners with the patient and whānau to manage needs, including anticipatory prescribing, while maintaining responsibility and oversight.
- The extended healthcare team are informed providers of patient care with delegated roles in administering anticipatory medications – working as an interdisciplinary team.

Who is this particularly helpful for?
- Those who prioritise quality of life.
- When there is a good shared understanding of the limited prognosis.
- When there are concerns around pain and distress.
- Patients who wish to remain at home.
- Those needing an alternative to repeated (avoidable) admissions.
- Those who are Māori, live rurally or have non-cancer diagnoses.
- When a patient's wishes need representing in an acute situation.

Triggers
- Recent hospitalisations.
- Proactive or prognostic tools (SPICT, *GSF PIG*, *Serious Illness Conversation Guide*).
- Thalamus data.
- Palliative care "register" at GP practice.
- Changed focus of care identified.

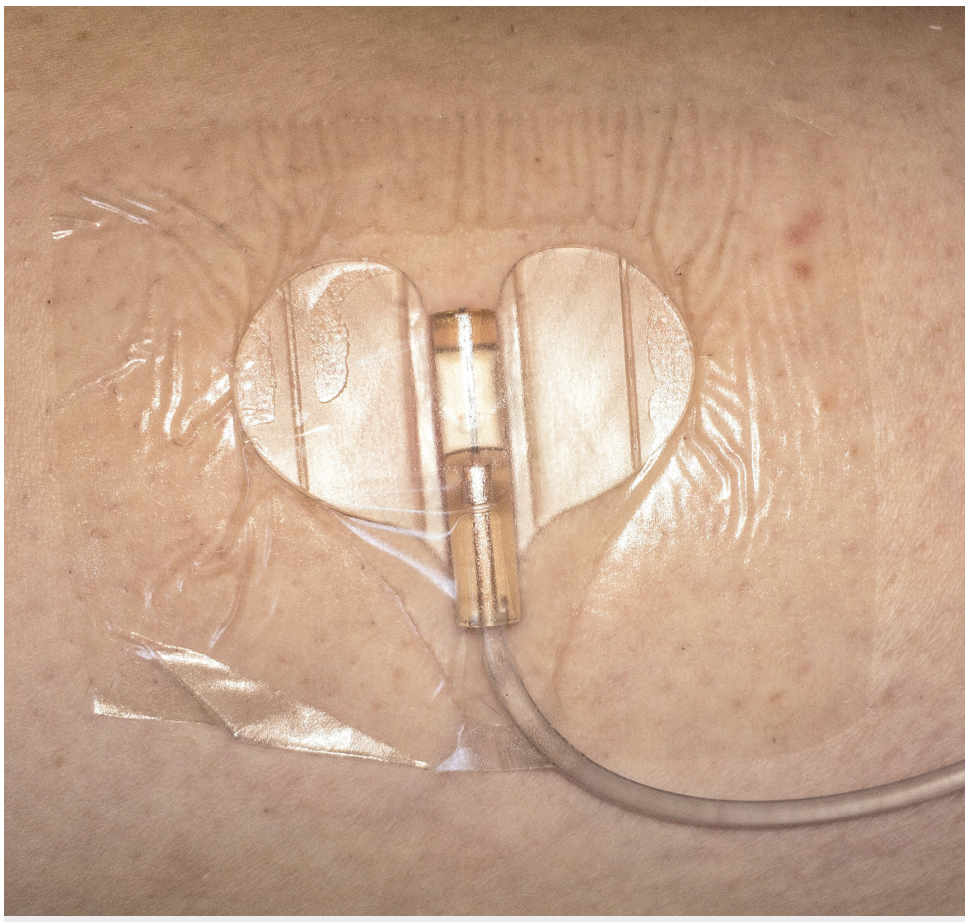
Exclusions
- No consent.
- Imminent death requiring specific medication approach.
- No capacity, advocate or enduring power of attorney.
- Child.

Patient example 1
You are looking after a patient with bowel cancer. They are receiving palliative chemotherapy, but their condition is slowly deteriorating. You feel that their prognosis is likely to be only a few months. On discussion with them, it is clear they are frightened of being in pain (which they do not currently have) and that quality of life is their priority. They wish to remain at home "at all costs", and they are realistic about their prognosis. You should consider prescribing Just in Case medications (see "Prescribe" section) for as-needed administration.

Patient example 2
A patient with stage IV heart failure has been told by their cardiologist that there is little more they can do to help their condition. You estimate their prognosis to be less than six months, but probably more than a few weeks. They have said that they do not want to go into hospital unless it is absolutely necessary.

During their last admission to hospital, they had a chest infection treated with antibiotics, and the patient would not rule out further active treatment if it is appropriate. You consider it quite possible that this patient will deteriorate, and this could happen acutely out of hours in circumstances where palliative control of their symptoms at home would be appropriate.

You should consider prescribing Just in Case medications (see "Prescribe" section), which would reduce delay in accessing injectable drugs for pain or breathlessness, and to enable initiating antibiotics out of hours. You may decide to annotate the drug chart to instruct the nurse/paramedic to contact the GP before administering a first dose as it is difficult to anticipate the circumstances in which they may be needed.


marcoventurini autieri – iStock.com

Giving medications subcutaneously can be an effective way to manage distressing symptoms

Who prescribes (or recommends)?
Any designated prescriber can prescribe the medications with the patient: GP, NP, specialist palliative care doctor or NP, hospital doctor or NP.

If the prescriber is not the GP, the prescribing needs either collaborative consultation at the time or a review and countersigning of the medications by the GP (or NP) within two to four weeks. Advise whānau/next of kin to call the practice to arrange review (costs *may* be funded).

Prescribers (as above) and non-prescribers (eg, ambulance personnel, nurses, allied health, emergency department and inpatient teams) may identify the need for anticipatory prescribing and recommend it directly to the GP or via the patient.

Prescribe
Consider prescribing for each of the common end-of-life distress symptoms:
- **Morphine or fentanyl (or both)** as options for pain.
  - Morphine helps with breathlessness as well as pain.
  - Fentanyl is recommended in the context of severe renal failure (eGFR <30ml/min/1.73m^2).
  - Morphine must be dispensed to the patient's home, but fentanyl is accessible to ambulance staff (see "To dispense versus not to dispense" below).
- **Midazolam** for agitation, delirium, restlessness.
- **Haloperidol** for nausea/vomiting.
- **Hyoscine butylbromide** for respiratory tract secretions.

Starting dosages of these medications are pre-printed on the "Just in Case Medication Prescription" chart. Each medication must have a prescriber signature, printed name, and date. Dosages can be changed if opioid tolerant.

Consider prescribing additional medications (which can be directed to family, nurses or ambulance personnel to initiate). Examples are subcutaneous levomepromazine (in aged-care facilities); oral clonazepam, morphine, antibiotics, steroids, aperients; rectal suppositories/enema, diazepam. In close consultation, intravenous frusemide is also possible. Contact Just in Case plan programme lead.

To dispense versus not to dispense
This is where a shared decision can be made whether to have the medications dispensed to the patient's home or to rely on the stock of the St John ambulances. Fentanyl and midazolam can be accessed by appropriate St John staff. Haloperidol and hyoscine butylbromide medications are supplied under a Practitioner's Supply Order to these ambulances. As of 2023, St John can give SC/IV/IM droperidol for end-of-life indications. Morphine is not carried, but it can be administered by St John personnel if supplied to the patient.

Key considerations:
- Whether management of medications in the home is acceptable to the patient/whānau.
- The risk of medications expiring before needed.
- The risk of wastage if not used.
- The risk of diversion.

Sharing
- Original copy to patient (to keep above their fridge).
- Next of kin may keep another copy (eg, on their phone; optional).
- Copy for GP practice management system.
- As appropriate: copy for aged-care facility notes, hospital notes.
- Courtesy notification to hospice team.
- Copy to Health Records – via eReferral (BPAC) if external (most secure) or send an email to medical.information@bopdhb.govt.nz if internal.

Management
- Assessment as per St John guidelines or *Te Ara Whakapiri Toolkit*.
- Discussion with whānau/family, GP (where possible), hospice (as applicable), clinical desk (as required).
- Manage as appropriate. Use code referral@justincase in disposition notes and "palliative" as a clinical impression.
- Put plan in place for follow-up if the patient is left at home. Copy of notes to GP.
- Transport to hospital if it is in the best interests of the patient and they consent to this.

Strategies to enhance guideline uptake and impact

It is widely acknowledged that achieving good guideline use and adherence in clinical practice is challenging worldwide. Dominant and competing discourses influence and prevent consistent application. While not unique to palliative care, a strong competing discourse has been found between the caring perspective that is needed in palliative care and the curing and organisational perspectives that dominate medicine. A strong approach to enhancing guideline uptake and impact is needed, and one that allows interventions to be tailored to suit the context.

Adopt strengths of project management

The application of project management principles is known to facilitate a range of processes necessary to achieve the desired results and benefits in healthcare. Some of the fundamental principles of project management include:

- involving different stakeholders to set the goals, expectations and benefits
- creating a greater awareness of how to achieve the objectives and benefits
- establishing a formal method to plan and evaluate the goals and expectations set initially
- creating a learning and improvement environment.

Project management can help to create engagement and commitment at organisational levels, integrate this with stakeholders at all levels, and assist in shaping a culture where guideline use is encouraged. This multi-level integration approach is vital for the discourse to change.

To ensure an equitable approach to the palliative and end-of-life-care population, undertaking project management within a locality, PHO or general practice may be appropriate.

Identify barriers and enablers

It is crucial to consider the risks associated with an implementation project early on. Early planning serves not only to identify both enablers and risks but also to create opportunities to reinforce and mitigate them appropriately. Attitudes and behaviours related to implementation should be documented within the project management framework, utilising tools such as a lessons learned log and a risk register, collaboratively developed with stakeholders.

> “We found that most barriers stem from a lack of expertise and teamwork”

Research can serve as an early source of information on influencing factors. For example, our recent realist review identified the enabling themes of anticipatory prescribing to be expertise, teamwork and prioritisation.[1] These themes were used to categorise barriers, enablers and behavioural attitudes, as illustrated in Table 2.

Promote capability

We found that most barriers stem from a lack of expertise and teamwork.[1] Despite the expectation for primary palliative care providers to provide most of the palliative care, the knowledge and skills of these providers are varied and can be limited. The ways these providers integrate their care approach with other providers are also considered to be variable and limited.

If the expertise and teamwork themes were woven together as a collective expertise, however, the barriers could be addressed from a “one team” perspective – a strategic and patient-centred goal of the *New Zealand Health Strategy*. Building collective capability would need to have a good level of commitment from the various stakeholders involved in the project management group and be managed collaboratively.

The implementation project would include collaborative approaches to making the guideline visible, with an expanded approach to education. Integrating education into existing learning platforms and providing knowledge of the problem, not just the solution, will inform not only what to change but why and how. A systematic approach to interdisciplinary education is necessary, and collaboration with relevant educators could facilitate this process.

Navigate interprofessional relationships

An intentional approach to addressing potential conflicts in interprofessional relationships is also indicated. Recognising that misunderstandings and hierarchical issues could impede effective implementation forms the basis for a collective strategy. Commitment from the stakeholder team is vital in this approach. Several principles highlighting the enablement of respectful interprofessional relationships, with patients rather than professionals at the centre, are provided in Panel 1.

Promote environments of change

Within healthcare environments, there are systems and demands that can reduce the potential to achieve integrative patient care. Increasing the visibility of the models and systems that enhance anticipatory prescribing (Panel 2) could inform general practices regarding what healthcare improvement initiatives to pursue.

Enable consultation

A final evidence-based approach to implementation is the provision of a consultation period. Active consultative engagement would be invited from those with an interest in this topic and from those most affected by the guideline. Engagement would be sought with stakeholders who represent various cultural, regional and sectoral contexts, professional disciplines and national bodies – for example, BPACnz and the Health Quality & Safety Commission.

A request to engage face to face with tangata whenua, the local iwi, with acknowledgement of tikanga, would be made. Publishing articles in research and health professional journals would be a further strategy. For completeness, it would be ideal to consult with patients, who sit at the centre of this guideline. If research partnerships and ethical approval were put in place, this could also be carried out.

All feedback would be acknowledged, with careful, considered, collaborative decisions of what to enact. ■

Feedback to ruth.mcchesney247@gmail.com

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Key points

- Challenges in New Zealand’s end-of-life care prompt the proposal of anticipatory prescribing as a solution.
- Implementation focuses on expertise, teamwork and prioritisation, emphasising interdisciplinary collaboration.
- The guideline stresses cultural responsiveness, patient-centred care and effective adoption strategies.

PANEL 1.
Management principles for successful interprofessional relationships

- Whakawhanaungatanga – connecting and forming relationships
- Using a patient-centred approach to frame discussions
- Using an evidence-informed approach to make decisions
- Being open to varying perspectives from different disciplines
- Engaging in self-reflection
- Engaging in respectful discussions
- Reflecting on the perspectives of all team members
- Sharing one’s own perspective and rationale

PANEL 2.
Models and conditions that enhance anticipatory prescribing

- Nurse practitioners
- A flexible primary care model (eg, Health Care Home model)
- Telehealth options
- A champion role (eg, GP and registered nurse)
- A GP dedicated to an aged-care facility (for continuity)
- Shared care platforms
- Integrated IT systems
- A palliative care register
- Cultural responsiveness, such as Te Whare Tapa Whā (multi-dimensional care)

TABLE 2. **Factors influencing anticipatory prescribing**

Barriers	Enablers	Behavioural attitudes
Time consuming	Education	Variation within general practice
Difficult conversations	Identifying palliative needs early (tools help with this)	Wary of new ways of working
Lack of confidence/skill/experience, and fear of upsetting patient	Setting up good conversations around serious illness	Paternalistic approach versus partnership approach
National training of *Serious Illness Conversation Guide* less compatible with general practice model	Communication and trust between disciplines	Workplace culture and attitude towards anticipatory prescribing
Fear of potential misuse of medications; fear, rather than a risk-versus-benefit decision	Shared care platforms for communication and updates on patient care	Attitudes towards other disciplines
Incorrect/incomplete completion of prescriptions preventing the legal dispensing or administration of medications	Early adopters/champions, especially NPs	Navigation of interprofessional issues, hierarchy issues, conflicts, negotiations
Poor understanding of other health professionals’ scope and roles	Sufficient link between patient and GP	Perception that patients who call an ambulance want to go to hospital
Manual process involved	One assigned doctor per aged-care facility to facilitate nurse trust and provide continuity	Wanting to prevent work for colleagues out of hours
Demand for immediate care over a proactive approach	Electronic forms that integrate with systems	• Awareness of benefits of anticipatory prescribing • Proactive practice mindset • Adherence to best practice

KEY: Expertise Teamwork Prioritisation