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NHS Lothian Health Services Research Programme

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| Project title: Investigating the contribution of Community Nursing to Anticipatory Care | |
| Start date: April 2008 | Finish date: April 2009 |

Investigators:

| | |
|-----------------------|-------------------|
| Prof Catriona Kennedy | Catherine Mahoney |
| Jean Harbison | Linda Veitch |
| Alison Jarvis | |

1. Summary (Background and Literature Review)

Background

Delivering for Health (SE 2005) identified the need to shift the focus of care from acute care towards health improvement, self-care and preventative medicine. The emphasis is on targeting resources for those most in need and for the proactive delivery of anticipatory care. Building on this, the Review of Nursing in the Community (SE 2006) proposes a generic community nursing role with supporting self care and anticipatory care as two of the underpinning seven principles of care delivery (Jarvis 2007). Delivering Care, Enabling Health (SE 2006) which is the Nursing, Midwifery and Allied Health Professional response to Delivering for Health, similarly stresses the need for proactive interventions.

'Anticipatory care' (AC) was the term given to an approach to working with individuals to help them identify early any circumstances which may have a negative impact on their long term conditions and support them to develop strategies to avoid them or reduce their effects (SEHD 2006). 'Self management', as an element of anticipatory care, was defined by the Long-term Conditions Alliance for Scotland (2008) as the successful outcome of the person and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long term conditions.

However the evidence is limited and little is known about how anticipatory care and self management is understood and delivered by community nurses (CN) (Kennedy et al. 2008).

Literature Review

A review of the United Kingdom literature spanning (1998-2008) was undertaken to assess the extent and nature of evidence on how community nurses contribute to anticipatory care in relation to self support/management. 432 potential papers were identified and through a process of criteria based screening, these were narrowed down to 21 papers directly addressing the key question, which were sorted into 3 key categories: anticipatory care (12), supported self care (5), and anticipatory and supported self care (3). This classifying strategy was undertaken for pragmatic purposes, as there is little agreement in the literature as to definitions and characterisations of either of these concepts, and to how they are related to each other. All studies were small scale, with the majority being single centre. The majority used qualitative (12) or mixed (3) methods, with (5) quantitative studies, of which only one was an intervention study.

Anticipatory Care

Armour (2007) and Stewart, Dyas and Brown (2006) in evaluating professional roles in anticipatory care demonstrated that some roles by their nature are effective in anticipating needs in long term conditions.

Kennedy (2002), in her work on initial assessment, demonstrated that an important aspect of district nursing work is the identification of a range of possible futures for patients (anticipating change). This need to look ahead in time for individuals is reflected on a population basis in Barnet's (2006) evaluation of a COPD Winter Forecasting Scheme to target patients at greatest risk of hospital admission with the aim of starting treatment early. However, this evaluation was inconclusive and did not demonstrate clear effectiveness.

Risk screening for coronary heart disease has been undertaken (Maggs & Fox 2007) and this was shown to improve health, facilitate referral and assist access to services. Community healthcare packages were delivered and evaluated by Abbot, Johnson & Lewis (2001) in terms of patients and carers experiences and although comprehensive management was valued, patients reported dissatisfaction with services, lack of care co-ordination and difficulty in accessing information.

A series of studies identified barriers to anticipatory care: these included ineffective referral, lack of in-depth knowledge about long term conditions, receptiveness of patients to education and support and a lack of nursing resources (Lewis and Anthony 2007; Stewart, Dyas & Brown 2006; Arnold, Topping and Honey 2004; Kneafsey, Long & Ryan 2003; Sargent 2002; Davies 1999; Cantrell 1998).

Supported Self Care or Self Management

Watson, Mylote and Procter (2003) and Walsh, Yardley & Donovan Hall (2007) obtained positive evaluations of two programmes provided for specific client groups (Chronic Obstructive Pulmonary Disease and Vestibular Rehabilitation) which aimed to enhance self care and reduce hospital admissions. However, one study demonstrated the ambivalence of patients' perceptions of self management (Jones, Pill and Adams 2000) and raised doubts about the likely success of self

management plans. Two studies revealed a lack of documentary evidence of how nurses support self care (Macduff and Sinclair 2008) and a lack of initiative in encouraging this and a need for long-term conditions education (Macdonald et al 2008).

Anticipatory Care and Supported Self Care

Patients with ischaemic heart disease reported that the practice nurse led clinics provided reassurance and motivated them to make or continue making lifestyle changes (Wright, Wiles and Moher 2001). Curry (2006) studied an Urgent Care Team Service for patients with chronic obstructive pulmonary disease, designed to enhance patient self care and reduce hospital admissions. Patients reported that the service improved their care. Practice nurses providing care for diabetic patients, despite not having been educated in diabetic management, felt they offered holistic care and contributed to patient education, seen as vital in maintaining the individuals' independence (Gillibrand, Taylor & Hughes 2004).

Summary

This literature review revealed that specialist roles, services focused on specific long term conditions, and patient education initiatives have been shown to improve both anticipatory and supported self-care. A need for relevant nursing education emerges, as does the existence of significant barriers to providing anticipatory care. Interpretation of the evidence, however, is constrained by the lack of clarity and consensus as to the nature and boundaries of 'anticipatory care' and 'supported self-care'.

2. Original aims

The original aims of this proposal were to:

- Study one aspect of anticipatory care (promotion of self care and support) to investigate how it is understood and delivered in practice
- Articulate the nursing contribution to anticipatory care
- Identify skills and competences required
- Inform identification of potential outcome measures

Research questions

- What do Community Nurses (CN) understand by the term anticipatory care?
- What activities do CNs undertake which are identified as 'anticipatory care' (promotion of self care and support)?
- Do CNs do anything else which could be regarded as anticipatory care, but is not overtly identified as such?
- What skills/competences/knowledge are they using to undertake this work?
- What facilitators/barriers to anticipatory care do they experience?
- What feedback (if any) is used to assess the effectiveness of anticipatory care activities?
- What are patients' experiences and perceptions of what their self care needs are and how are these met?

3. Methodology

Qualitative research is particularly suited to the study of phenomena about which little is known and was the chosen approach for this study. From experience in clinical practice, and from the literature review, we know that:

- Current policies identify the provision of anticipatory care by nurses and others in the community as crucial to meeting the needs of vulnerable people
- To date, little is known about how anticipatory care is understood and delivered in the community.
- Nurses in the community are already contributing to anticipatory care and there is some evidence that this approach works. However, this work is often 'hidden' as it is integrated with routine care of those who have health problems or more complex illnesses.

For all these reasons, a qualitative approach using observation and individual in-depth interviews and focus groups was selected in preference to a questionnaire for data collection (Guba & Lincoln 1994). Observation is considered essential in the process given the acknowledged limitations of self reporting (Carroll and Johnston 1990).

Ethical approval

Ethical approval was obtained from NHS Lothian Local Research Ethics Committee and Edinburgh Napier University. The study was conducted within the terms of NHS Lothian research governance processes. Informed consent was obtained from all participants. All data remained confidential throughout the project.

Data Collection

Data were to be drawn from two participating health centres in NHS Lothian which had been determined at the start of the project.

This study was conducted at the same time as other data collection such as the Baseline Study for the Review of Nursing in the Community, the Community Nursing Census and the Nursing & Midwifery Workload and Workforce Planning Project use of the Professional Judgement Tool. There were therefore a number of demands on practitioners' time. One of the health centres withdrew from the project prior to data collection. Despite this, purposive sampling enabled the researchers to approach other suitable participants; this took unanticipated time, further negotiation and resulted in adapting the initial sampling and data collection techniques. Although nurse/client observation was achieved, it was not always possible to interview nurse and client separately post observation. Focus groups were carried out with nursing staff (District Nurses (DN), District Nurse Team Leaders, Practice Nurses (PN) and Health Visitors (HV)); however GP's, Nurse Managers and Practice Managers who were initially approached declined to participate.

Table 1: Data Collection

| Data Collection Tools | Participants | Total |
|---|---|--------------|
| Focus Group 1 | District Nurses (n=4) Health Visitors (n=3) Community Nurse (n=1) District Nurse Student (n=1) | n=9 |
| Focus Group 2 | District Nurse Team Leaders (n=2) | n=2 |
| Focus Group 3 | District Nurse Team Leaders (n=2) District Nurse (n=1) Anticipatory Care Lead (n=1) | n=4 |
| Focus Group 4 | Lead Practice Nurse (n=1) Practice Nurses (n=9) | n=10 |
| Focus Group 5 | Lead Practice Nurse (n=1) Practice Nurses (n=8) | n=9 |
| Individual interviews Community Nurses | Team Leader (n=1); District Nurse (n=3); Practice Nurse (n=2) | n=6 |
| Patient Observation | Team Leader patients (n=3); District Nurse patients (n=3); Practice Nurse Patients (n=3) | n=9 |
| Patient interviews following observations | IMPACT service patients (n=3) Practice nurse (n=1) | n=4 |

A total of five focus groups, nine nurse/patient observations, four one to one interviews with patients following interviews and a further six one-to-one interviews with community nurses were held.

The intention was to record all focus and individual interviews. All participants of focus groups agreed to this. However, of the 6 individual interviews, 3 participants requested not to be recorded, expressing concerns that this would hinder their freedom to speak. On these occasions, the researchers obtained permission to take detailed field notes. In the patient observation events, recording conversations was inappropriate due to either the nature of the environment or the vulnerability of participants.

Constant comparative analysis enabled comparison of emerging themes and refinement of data collection from one focus group/interview to the next.

4. Findings

Community Nurses understanding of the nature of anticipatory care and supported self care

The majority of participants, both PNs and DNs, associated the term 'anticipatory care' as '*avoiding hospital admission*'. However, they did acknowledge this interpretation reflected the current healthcare climate.

*"Anticipatory care is looking at... well one of the things, I suppose, **avoiding hospital admission** really, anticipating like having a care plan*

for patients so that if symptoms develop there was a plan that what you would do when symptoms may develop". [DN]

"Anticipating what could go wrong with a person and trying to prevent them going into hospital." [PN]

They were conscious that at times hospital admission would be the right intervention. One PN described how she would hate to think of any patient struggling at home if they were unable to breathe, thinking that they were not able to contact the hospital for help; she related that she was reluctant to discourage any patients from presenting at hospital.

"...and I truly feel especially with the respiratory, if somebody can't get breath, you know, no matter what, there's no way you can keep them at home...". [PN]

There were differences of perception as to whether anticipatory care was a new activity, and these perceptions were related to how the concept was understood. Practice nurses had a clear understanding of anticipatory care as the monitoring of long term conditions and as such perceived this to be a new activity for DNs. Some District Nurses' perceptions were consistent with this, obviously identifying it as a new initiative.

"So I think what it is, we're positive about the anticipatory care but to be able to provide that service you need more resource". [DN]

"You identify the group at risk and then go in proactively and manage their disease, that's the idea in a nutshell..... But it's not that easy. Huge problems with the data....." (DN – team leader)

Other DNs however referred to their long tradition of monitoring patient problems, seeing this as anticipatory care activity which they had done for years but which remained unlabeled.

"Well, I actually think that we... it's a role district nurses have done for years but it's not had a label put on it". [DN]

This interpretation caused some anxiety; DNs felt that this role was compromised by the cessation of supervisory visits, which made anticipating care needs for patients with long-term conditions more difficult.

"For many years we used to do what we term as supervisory visits, which in essence was actually monitoring patients for anticipated problems, but through time and service need the supervisory visits got dropped off the end..." [DN]

Health Visitors (HV) did not identify with the term anticipatory care in terms of their role.

"As health visitors we had a difficulty getting around this anticipatory care and self assessment, but I suppose because the families we have are well families and there's very, very few that have complex needs..." [HV]

Participants were less familiar with the concept of supported self care. One DN described it as being *'not something we do at the moment'* [DN] another referred to it as a *'theory'*. Initially some DNs felt that if patients were able to self-care, characterising these as the *'walking well'*, then they were more likely to be attending a health centre and not coming to them, therefore it was something which the PN might more frequently deal with. However on further discussion, DNs recognised that patient education or facilitating independence could be viewed as supported self-care and in that case it was something they all did.

"I suppose supported self-care could just be if you've got somebody who's got complex needs that have a carer or a husband who you're supporting them to look after their catheter or changing their leg bags and things like that, that would be supporting them in their self-care...". [DN]

Despite this difficulty in articulating supporting self management, observational data of DNs on home visits confirmed that in the home they acted to promote self care: for example, allowing a slow moving patient to carry out activities without intervening to take over.

PNs recognised self care as something they would frequently encourage patients to do through patient education during appointments and occasionally home visits. PNs saw patient education as a central element of the care they provided which enabled anticipating care needs, promoting health and patient independence.

One PN offered the following comments;

"...you are obviously helping them steer their own care by themselves..." [PN]

"Well historically I think practice nurses did the bulk of all the chronic care. Em, it's only in the last couple of years really that district nurses have become involved". [PN]

HVs supported this perception and articulated their substantial role in promoting health to enable independence.

"You never do anything for anybody if they could be doing it themselves..." [HV]

Clearly there was little consensus as to how these concepts of anticipatory and self care are understood. Practitioners are familiar with health service policy and initiatives, there was no clear consistent indication of how these are translated into practice, and how the policies and initiatives mesh with pre existing understandings of anticipatory care. While the project was planned with a clear concept of supported self care as an element of AC – practitioners did not seem to differentiate.

The community nurses' contributions to anticipatory care

The analysis above reveals a lack of clarity and consistency in the understanding of anticipatory care and supported self management. This makes it difficult to delineate the respective contributions of DNs and PNs. However, these data suggest that the employment context determines the approach of the nurse which in turn determines mindset and activities.

DNs saw their contribution as providing care for people with long-term conditions who had more complex care needs. Their focus on holistic care provided in the home, with a mainly unspecified diagnostic group – the frail elderly contrasts with that of the PNs, with their GP practice work setting, offering specific advice and care tailored to those with clearly identifiable long term conditions. They reported that this made it difficult to provide holistic care.

The following two extracts from observational data clearly demonstrate these two different approaches.

- *PN: 'If your chest is tight you should take another puff on your inhaler'*
- *P: 'I don't like taking more of my inhaler than it says so'*
- *PN: 'Your peak flow is lower than it should be and worse than the last time I saw you'*
- *Observer's notes: conversation identifies patient is 'frightened' to take any more of her medication but nurse does not pick up on this and focuses on the condition*
- Patient to interviewer following clinic appointment
- *'I have had asthma for 26 years and am not happy to change the dose of my inhalers without the advice of the Dr'*
- *'My asthma is very well dealt with by the PN.....I feel I get support with the physical but not the emotional'*

There is a clear focus here on consulting the protocol and considering the potential consequences of inadequately managing the long term condition.

In contrast, the DN below responds to the patient's priorities in self management:

- *DN to observer: 'we are just going in here to give some eye ointment, be very quick.....'*
- *Observer's note:*
- *Patient, George, raised the issue of needing help with shopping*
- *DN: have you got the frozen meal service? How do you get to the shops?*
- *George: 'Well my daughter takes me but my legs 'give way'*
- *DN: There is a waiting list for shopping but might be able to get a trolley with a seat so your daughter could still take you*
- *Observer's notes:*

- *George then told DN he had fallen a few times – DN suggested a stick – George not sure but he was won round and said 'I might consider it, perhaps you can bring me a stick.....'*
- *Eye drops given' written in the notes*

Often, departures from planned activity such as this remained unrecorded, as did actions taken in response to them. Care that could be construed as contributing to anticipatory care and facilitating self care remains unrecorded and therefore may not be overtly identified as anticipatory care, as it is often not the primary reason for the home visit. This invisibility of work was a persistent theme throughout.

All participants saw anticipating care needs and looking forward into the future as an integral part of the nursing role, however they seemed to consider different potential scenarios, depending on their role. Nursing questions and actions hinged on anticipating what sort of path patients might follow and putting something in place to allow them to manage it themselves.

Knowledge, skills and educational needs

Education was identified by all participants as being an important element in enabling and improving anticipatory and supported self-care, and in the context of education, these concepts seemed to be understood by some DNs as a new service, focused on the management of long term conditions.

DNs recognised a need to extend their physical assessment and management skills in order to participate in the current agenda for long term conditions. Some of the participants were undertaking a course in which anticipatory care was being addressed as an individual educational need for community nursing staff. Some were currently being taught advanced clinical assessment skills, this however seemed a source of '*stress*';

"...at the end of that we're expected to pass an exam on clinical... now [name], who's done all that, she said, "You've got to spend hours doing that before you're competent..." [DN]

DNs were concerned that they might have to do '*every course known to mankind*' if they were to become experts in long-term conditions. However, they related inequalities in terms of accessing courses due to geographical location and a lack of adequate variety of courses about LTC.

PNs in contrast reported that their educational needs were generally adequately addressed;

There's lots of days... study days. There's lots of opportunity for education to follow. [PN]

Many PNs received training which was required by their employer and addressed the needs of the practice population.

The education and skills training described above is clearly related to procedural and propositional knowledge and supports the delivery of both forms of

anticipatory care. However it appeared that an additional form of knowledge was required in order to deliver anticipatory care without the use of a disease protocol.

The extract below indicates the nature of the knowledge base required for the form of AC delivered by DNs to be effective. The nurses in these instances, in addition to their formal technical knowledge base, appear to have developed extensive domains of knowledge related to individual patients' lives, families and local communities and services, and appear to integrate these domains in order to initiate 'custom made' actions which are designed to keep this particular individual independent and self-reliant.

This was illustrated during an observation conducted with a Team Leader who was carrying out a visit to a patient with COPD who had been recently diagnosed as a diabetic.

Team Leader enquired how patient was, patient replied 'oh I'm fine', 'really you're fine? What's happened to your hair?'....'was [daughter] not able to take you on Thursday?' [to her weekly hairdresser appointment].

Patient – I just dinnae feel up to it

Team Leader – What do you mean?

Patient – I have been really sick and have ne eaten for two days....

The nurse does not accept an answer at face value, but draws on knowledge of this patient's life to explore further and bring to light a potential threat to self management.

DNs clearly saw relationship building as an important skill related to anticipatory care and supporting self management, and also saw this as an unacknowledged and undervalued skill.

...district nurses have always built up sort of therapeutic relationships with their patients and that's the important.. of the banter, we will certainly be open and you can be open with them and they respect you and they feel like they can trust you then people will open and are more open with the change..... that skill set is there, very much..... And sometimes, you know, people don't recognise actually the skill set that DN's already have.....

... but if you don't tease it out, and academically structure it into a model that says we do this, this and that, then it's maybe not recognised, it doesn't mean it's not valid

Facilitators and constraining factors for anticipatory care

Community nurses were aware that there was both a Scottish Government and public expectation for the care of patients with long-term conditions to improve. CNs identified with this need, but expressed great '*frustration*' in attempting to meet these expectations.

Concerns included a lack of resources (primarily adequately skilled staff), increases in the size of caseloads per nurse as a result of services designed to address anticipatory care (DNs related that caseloads were already unmanageable), a lack of funding, particularly sustained funding, IT and

administration support. This appeared to be more significant for DNs, but impacted on PNs. These concerns are illustrated in the extract below:

Well, they (DNs) have the carenap paperwork (single shared assessment tool), which is a huge bit of bureaucracy that they've got to fill in for each individual patient. I suppose we're at an advantage because we have the patient record and most of us are now... it's all on the computer or partly..... So it's all sitting there, so we really only have to record each consultation, whereas the district nurse has to get all that information and hold it together for individuals. (PN)

Yeah, because we had a, you know, a sort of hiccup because we have a patient, say for example on Warfarin, and they're housebound. Erm, the district nurse, and you can understand why, is extremely reluctant to go in just to do a blood test for the Warfarin, because of the amount of paperwork it involves to do that. So they don't do it. You know.. (PN)

Res: So does that mean that you actually go to the patient to check their warfarin?

Yes. But that doesn't happen for all practices. (PN)

In addition to infrastructural constraints, participants felt strongly that if initiatives and developments in anticipatory care were to be achieved effectively, a more 'joined up' approach to working was required. A lack of 'joined up working' between services was perceived as creating a significant barrier to anticipating and organising care needs. Different practices and different services had very different ways of working which impacted on delivery of AC.

"I think there's a lack of joining up of... it's like our service, the anticipatory care, the IMPACT service(Improving Anticipatory Care & Treatment service which is a nurse led service for the management of long term conditions , and there's too many bits to it." [DN]

Communication between practice teams and other healthcare professionals seemed to vary. Some teams reported good communication between DNs, HVs, PNs and GPs, however in areas where dedicated anticipatory care services, for example IMPACT Service, were being set up, communication seemed to be an issue.

It's a huge bit about communication, that, as always, is a big problem but as time goes by we're finding there's more and more and issues about communication. [Team Leader]

Furthermore, inequalities in service provision for different long term conditions were identified as a constraining factor. Participants related that conditions such as cancer were far better supported compared to conditions such as COPD.

Feedback, assessing effectiveness, potential outcomes

Current data (Scottish Prevention of Admission and Readmission to Hospital (SPARA) data) used to identify caseloads was reported as being inadequate and that a *true* picture of the potential effectiveness of services such as the IMPACT

service may not be possible. Participants hoped that as data improved and became more accurate, a clearer picture of effectiveness could be established. Nurses involved in setting up dedicated anticipatory care services reported that it was 'early days' and that it was too soon to evaluate service effectiveness. However a key indicator of effectiveness, repeatedly cited, was hospital admission.

..I mean the whole anticipatory care model is really based on, and one of the driving forces behind it, is to reduce those re-admissions. So I mean, that's the basis of it...

Team Leaders, DNs and PNs considered that they were being required to target their services at the 'wrong group of people'.

"I think, we need to target people very early on that are just on the start of their illness so they will try and get them already thinking about managing their disease better, giving them more information so they're aware of what the disease is, and how it might progress..."[Team Leader]

Their rationale for this was that it was more effective to target people early to enable care planning and education in line with disease trajectory; furthermore at this point in the disease process it might be easier to instil the concept of independence, whereas it was more difficult to change the behaviour of those who had lived with a long term condition for years.

The extract above indicates the possibility that one potential outcome of disease focussed AC is an increase in early attendance.

Little evidence emerged of focused and systematic approaches to assessing effectiveness in care. When nurses did specifically consider outcomes, these were not always well articulated:

Practice nurses

I think in the main though, I think in the main, it has improved patient care....

..... It has raised the standards

I think it has, yeah. I mean they come, they come back to see you because you're a contact for them and they know you and sometimes its inappropriate, they should maybe be going to the doctor. But because they know you, you're the one who sends for them and does all their checks and stuff, they think, oh, I'll come and see the nurse. So I think yeah, the patients are getting a lot more out of it.

This exchange indicates that one outcome of PNs approach to anticipatory care may be increased willingness of patients to engage with health care. This appears to relate to the development of the nurse-patient relationship.

Outcomes can also be related to the patients' perspective and experiences. Many of the patients who were observed with the community nurses were elderly and had a variety of long term conditions. Patients' opinions of the nursing care they

received revolved around their appreciation of the nurse *being there*, someone they could 'trust' who was 'accessible' and 'approachable'.

"...she pops in and looks after me... glad of her visits.....I can phone her anytime..." [Patient, talking about IMPACT service]

They do what they say they will...' [Patient observation]

Patients similarly saw the DN as the pivotal person in their care management. Observational data indicated that this pivotal position allowed the DN to address gaps in service provision, and overall patients appeared to feel less vulnerable. This may be particularly the case with a vulnerable group in the community – the frail elderly.

It may be relatively straightforward to identify appropriate outcome measures for disease focussed AC, however it may be more problematic to assess the effectiveness of the other form, as care is highly individualised. For example, despite the emphasis on self care, some patients seemed reluctant or fearful to take on this responsibility, especially if it involved monitoring medications.

"I have had asthma for 26 yrs and am not happy to change the dose of my inhalers without the advice of the Dr..." [Patient]

5. Discussion

Participants recognised the importance of the policy agenda, although they had clearly different understandings of and approaches to anticipatory care and self management, depending on their roles and practice context.

The lack of clarity and consensual understanding of the meaning and purpose of 'anticipatory care' is very evident in this study, yielding similar findings to those of Wilkinson & Whitehead (2009) and Forbes & While (2009).

This appears to be due to the emergence of a policy initiative focused on reducing hospital bed usage and meeting public health targets, related to a client group with long term medical problems, using a variety of means which differ but are essentially pro-active in nature, which have been termed 'anticipatory care'. Implementation of this has been super-imposed on a long-standing way of practice in community nursing, which has been less clearly defined, but can also be defined as 'anticipatory care'. This latter is a more global and holistic approach, not limited to clients identified by medical condition, which uses as its vehicle the home visit by the community nurse, and which also is essentially a pro-active process.

These findings are consistent with the literature review undertaken for this study, which also indicated different conceptions of anticipatory care, which are related and interdependent. The two forms need different skills and knowledge bases, but clearly overlap.

For the purposes of this discussion, therefore, we have identified two forms of anticipatory care. Form 1 can be conceptualised as related to the policy agenda and the management of long term conditions and is protocol focused, and Form 2 is conceptualised as related to holistic care and individual patient focused, and

such is characteristic of essential nursing activity. Both forms are pro-active in nature.

Although these 2 conceptions of anticipatory care (for convenience termed Form 1 and Form 2 respectively) have in some ways become conflated, and cause confusion, nevertheless the evidence suggests that they are related to each other, and can operate together successfully and public health interventions work better if patients have good relationships with health service staff (Watt & Sridharan 2008, O'Donnell, Reid, Turner et al 2008). For clearly defined medical conditions, this relationship may be less significant – for example, in checking weather forecast to provide COPD intervention to a population, whereas when dealing with frail elderly, or complex problems, knowing the patient may be significant in providing tailored support to remain independent.

The lack of clarity about anticipatory care and supported self management, coupled with a general difficulty in seeing the 'big picture' because of continual service change may generate a tendency to work in silos of comfort, focusing on their own individual activity. This may contribute to the perception of lack of joined up working, and make it difficult to articulate how their own work, characterised as form 2, contributes to the overall agenda, characterised as form 1.

There is also the issue of defining desirable outcome states, which may differ between the two forms. The legitimacy of hospital admission rates as an indicator of effectiveness can be questioned. Certainly, in terms of Form 1 anticipatory care, this is a logical and relatively straightforward criterion. Respondents in this study adopting Form 2 did not necessarily view 'hospital admission' as a poor outcome of anticipatory care. Hospital admission for a short period of time, rather than being viewed as a failure of supported self care, can be viewed as an action which prolongs self management at home in the longer term. This suggests that more valid outcome measures require to be identified.

6. Conclusions

This study demonstrates that in the community nursing context, two different forms of 'anticipatory care' are in existence. These forms and the relationship between them appear to be governed by roles and practice context. Form 1 reflects Government policy, is strongly linked with long term conditions, and is clearly visible and articulated. Form 2 reflects long standing nursing practice, is strongly linked with people and their lives, and is less visible and less well articulated, and consequently may not be recognised as anticipatory care.

The study further demonstrates that although these 2 distinct forms can be discerned, they are related to each other in several ways. For example, policy led initiatives in the management of long term conditions may stand better chances of success if they are linked to individual lives via the medium of the community nurse. These relationships need further examination; it is suggested that the failure to clearly differentiate the 2 forms has led to miscommunication, misunderstanding and the lack of clarity which has so clearly been shown in this study and others. It is also clear that there is a population of individuals, e.g. the frail elderly, not identified as long term condition clients. They nevertheless also require anticipatory care and support with self management to maintain independence and reduce hospital admission. The evidence from this study

indicates that Form 2 anticipatory care may be particularly significant for this group.

In measuring the effectiveness of anticipatory care, adequate evaluation will depend on using appropriate methods. For Form 1, statistical data on population groups e.g. hospital admissions, is appropriate; whereas Form 2 requires more detailed analyses of such data, and perhaps closer engagement with users. Nevertheless there may be scope for developing systems of effectiveness evaluation which can encompass both forms of anticipatory care.

There is also scope to develop a more conceptually complex model of anticipatory care, building on this initial exploration, within which all aims, roles, practices and methods of evaluation can be located and clearly visible. This offers the potential to enable practitioners to interpret and apply policy – otherwise change may be limited and may result in service gaps. Conversely, a clearly integrated model of anticipatory care will assist policy makers to ensure the effective use of resources and avoid confusion and duplication of effort.

Limitations

This was a small-scale study, conducted at a time where community nursing services were experiencing significant disruption and proposals for change. The views expressed by nurses will clearly reflect this. This was a nursing study, and therefore multi-disciplinary perspectives were not sought, although we acknowledge the importance of this in delivering anticipatory care of both forms.

This study has not been able to demonstrate the role of HVs in anticipatory care. This was due to firstly difficulty in accessing HV participants, and secondly, there may exist a perception of anticipatory care as being linked essentially to the management of long term conditions in the adult population and difficulty in accessing HV participants.

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7. Importance to NHS and possible implementation

The lack of consensus of understanding of the meaning, purpose and outcomes of anticipatory care and the difficulties of many community nurses in articulating their contribution means that it is difficult to measure the effectiveness of anticipatory care.

The findings highlight the value of listening to patients' experiences of healthcare delivery to provide an understanding of the key drivers which could help to make

services more responsive to patients' needs and improve quality and outcomes of care.

There are clear implications around the disparity between educational opportunities open to the different groups of staff. Shared opportunities along with shared learning (where possible) are vital if nurses are to provide a seamless service to patients, acknowledging the respective roles of the different members of the nursing team.

There needs to be a better integration of care between the main providers of care – whether that is within health between staff working within a GP health centre and those employed by a NHS Board or broader to include social care providers and the voluntary sector.

A challenge for the modernisation of primary care is how self care can be approached in a way that is acceptable to patients and improves outcomes and equity of care.

8. Future research

In measuring the effectiveness of anticipatory care, adequate evaluation will depend on using appropriate methods such as statistical data on population groups e.g. hospital admissions, is appropriate (Form 1); and more detailed analyses of such data, and perhaps closer engagement with users (Form 2).

There may also be scope for there may be scope for developing systems of effectiveness evaluation which can encompass both forms of anticipatory care. which can encompass both forms of anticipatory care.

There is also scope to develop a more conceptually complex model of anticipatory care, building on this initial exploration, within which all aims, roles, practices and methods of evaluation can be located and clearly visible.

Further study exploring the role of HVs and other members of the multi-professional team in anticipatory care is recommended. This also links to the recommendations around developing systems of effectiveness evaluation which can encompass both forms of anticipatory care.

9. Dissemination

Findings will be disseminated to a variety of different audiences;

- Feedback to study participants via a copy of the executive summary with electronic link to full report

An executive summary will be sent to:

- The three chief nurses in NHS Lothian and the associated General Managers
- Nurse Director, NHS Lothian
- District nurse team managers in Edinburgh City
- Clinical Nurse Manager, responsible for IMPACT team in Edinburgh
- Associate Director of AHPs, NHS Lothian
- Nursing Officer, Primary Care, Scottish Government

Additionally,

- Two peer reviewed journal articles will be submitted
- Presentations at local NHS Lothian forums and Research Day will be submitted
- Conference presentations will be actively sought – e.g. RCN International Research Conference and the International Nursing and Community Health Care Conference Adelaide Australia (paper accepted for presentation in August 2009)
- Teaching opportunities for pre-registration and post-registration nursing students will be sought at Napier University, Queen Margaret University and Edinburgh University

10. Future research

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11. Research workers

Professor Catriona Kennedy Edinburgh Napier University (Grant holder and PI)
Jean Harbison Senior Lecturer Queen Margaret University
Alison Jarvis Project Manager, Review of Nursing in the Community NHS Lothian
Catherine Mahoney Edinburgh Napier University (Research Fellow)
Linda Veitch Edinburgh Napier University Lecturer

12. Financial statement

A Research Fellow, Catherine Mahoney, was employed from April 2008 until January 2009. All other costs as agreed and the project has used the allocated budget. A small remaining sum of £600 has used to contribute to funding for the presentation of a paper at the International Nursing and Community Health Care Conference Adelaide Australia in August 2009.