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Interaction between community pharmacists and community nurses in dementia care

Veronica M Smith considers how working relationships among community professionals can affect patient care

Abstract

There has been little research that explores the interaction between community pharmacists and community nurses and how this interaction could benefit people affected by dementia. Using information taken from a larger study, this article presents the views of community pharmacists and one community nurse on how their communication, information sharing and team integration may improve care for this patient group. The community pharmacists reported positive attitudes to supporting people affected by dementia, but they highlighted barriers to integrated team working. In contrast, the community nurse conveyed the belief that the community pharmacist was an integrated member of the community health team. Community pharmacists and community nurses are keen to interact with each other to support people affected by dementia, but this interaction stops short of collaborative, integrated team working. Further research is needed to address this issue.

Keywords

community nurses, community pharmacists, dementia, interdisciplinary team, integrated working, older people

IN A biography of sociologist Erving Goffman's work, Burns (1992) examined the 'situation' of interaction. He argued that interaction may be 'merely situated' or 'situated'. To be 'merely situated' is when people happen to be interacting socially, it is unfocused interaction. By contrast, 'situated' interaction is focused and dependent on there being a condition to justify a need for focus. When pharmacists know they are interacting with people affected by dementia, they may be viewed as having 'situated' interaction.

Literature review

The literature identified information sharing and collaboration between professionals as important for people affected by dementia, and found that this patient group would benefit from an integrated health team approach. Grand et al (2011) suggested that the complexity of dementia requires an interdisciplinary approach to treatment. Dementia is a term used to describe deterioration in cognitive and daily living functioning and has a number of classifications, the most common being Alzheimer’s and vascular dementia. The varied aetiologies presented by different types of dementia mean that different management strategies are required; some people will require pharmacological treatment, while others may benefit from non-pharmacological approaches (Moniz Cook et al 2012). For these reasons it is important that community pharmacists and community nurses, formerly known as district nurses, communicate regarding people who have dementia.

While et al (2005) found limited contact between community pharmacists and nurse prescribers, resulting in a lack of interdisciplinary working. Hudson (2006) suggested that when professionals collaborate there is a possibility of a shared commitment, which may present problems for those professionals who feel that their identity is under threat. Additionally, the shared practice of non-medical prescribing by community pharmacists and community nurses could be viewed as contentious where two professionals offer the same service. However, figures show that community nurses have relatively low rates of prescribing (Luker and McHugh 2002, Hall et al 2006), which suggests no threat to professional identity. Jones et al (2004) found interactions were the basis of improved collaboration between professionals and that this could be supported by technology (Jones and Thomas 2007).

To be integrated in a network, people must have a relationship with other people in it (Zhao and Elesh 2008), have something in common with...
other members, and wish to benefit themselves or someone else. Granovetter (1973) considered the idea of ‘weak ties’ in networks. This concept centres on the assumption that some networks have weaker ties than others and that some people in the network will promote their own gains over the needs of others, suggesting there are structural holes in the network. Kadushin (2012) discussed how there must be cohesion in networks for them to be effective.

The literature on interactions with pharmacists has focused on the working relationship between themselves and GPs, the complexity of which has been well documented (Hughes and McCann 2003, Bradley et al 2012). There is a paucity of research on pharmacists’ perceptions about lack of integration in the health team and, in particular, with community nurses. This is despite government policy (Scottish Government 2013) advising that pharmacists should be integrated in health and social care teams to provide maximum benefit to patients.

This article is drawn from the findings of a larger study, carried out in Scotland, which aimed to explore the experiences of community pharmacies delivering services to people affected by dementia, and the facilitators and barriers to these services.

Method

The methodology for the larger study was qualitative, using semi-structured interviews with people who worked in pharmacies, and with healthcare professionals who had professional interactions with community pharmacies. The participants comprised seven community pharmacists, two accuracy checking technicians and one community nurse. Barbour (2008) advocated use of semi-structured interviews to enable participants to have confidence to draw attention to and introduce a particular subject. This confidence facilitated a smaller exploration of the views of community pharmacists and community nurses about their interactions and how these may affect people living with dementia.

Ethical considerations Ethical approval was granted by the School of Applied Social Science at the University of Stirling, and the study was adopted and approved by the Scottish Dementia Clinical Research Network.

Findings

Communication In networks, communication may improve service provision to people affected by dementia, or act as a barrier to care. Communication networks were explored. Participants had differing views about communication with nurses:

‘We have a good rapport with the district nurses and there are a couple of mental health nurses who have called on us at some point over the last two or three years for an input, you know with one of their patients’ (pharmacist 1).

‘We have probably got good bonds with some of the care teams, if that is the right way to refer to them’ (pharmacist 2).

Pharmacist 3 thought rapport with community nurses had improved, and that the relationship was now close:

‘Very much the relationship with nurses has improved over the years, I mean district nurses, we have a very close relationship with them. That helps how we can identify people who are vulnerable in the community and then work better together to try and help them, so it has been quite a shift over the last few years’ (pharmacist 3).

Pharmacist 4 appreciated that, like the pharmacy, community nurses worked with different GP practices:

‘The district nurses aren’t really linked to one practice anymore so it is hard to get a hold of the nurse. But I think maybe that if the practice for the patient and nurses and ourselves all kind of speak to each other in some way, it would make things easier because you would know what is happening’ (pharmacist 4).

The community nurse described knowing the pharmacist and the patients well in a small community:

‘I work in very small communities. When I go into a pharmacy and speak to the pharmacist I will say the person’s name and the pharmacist will say to me, “Oh, Jeanie.” They know the patient right away, they probably know the family, so I suppose that is probably the best thing about it. It is not like walking into [large chain pharmacy] in Princes Street in Edinburgh – it would be different all together’ (community nurse).

The nurse specified that sometimes he would not be at the pharmacy for a while; this was dependent on his caseload and whether he had reason to visit the pharmacy.

The accuracy checking technician described how she routinely communicated with the GP, the memory clinic staff and patients to let them know she was aware of all the different routes by which patients may be receiving medicine:

‘One of the guys who works in the memory clinic and one of the nurses come in quite frequently so they are aware we are aware of the clinic that they do. We have the prescriptions coming in from them and we try and match them up with dosette box patients. We also sometimes get just the normal
prescriptions from the surgery and then their nurses will come in and say can I get that added in and I might be changing it over the next few weeks, is that okay? So we are aware of that, as well as matching it up, making sure we are not just the middle man’ (accuracy checking technician).

The accuracy checking technician described how much work she was doing to match up medicines for people affected by dementia, which was not always recognised by community nurses.

The community nurse knew about technicians because he had met them at the hospital when he undertook prescriber training. However, he did not know much about their position in the community pharmacy:

‘Pharmacy technicians - I had some contact with them but not at the community pharmacy. I spent some time at the hospital when I was doing my prescriber training, not a great deal. They were telling you how the pharmacy worked and around the hospital they did a lot of checking and dispensing’ (community nurse).

Sharing information The literature identified information sharing between professionals as important for people affected by dementia (Grand et al 2011). Pharmacist 5 suggested that sharing information was inconsistent, highlighting malfunctions in the healthcare network:

‘She was a nurse from the anticholinesterase clinic up at [name of memory clinic], but the prescription was just handed straight over, so that fails. But when we have to phone the day centre then they are very helpful. Occasionally we are phoned by a psychiatric nurse who is saying we have this patient and we are really having trouble to get him to take his medication. Yeah, so I wouldn’t say it is seamless’ (pharmacist 5).

Pharmacist 4 thought information sharing was not good and illustrated this by describing an incident with medication:

’No, not really because there are a lot of things that happen to patients and you don’t find out. Like I had come across one time when somebody had a community psychiatric nurse and we didn’t know about it until they came in regarding a patient’s medicine... I think if we got more information about things it would help, especially with elderly people. They have got carers and district nurses visiting them, but we never know’ (pharmacist 4).

By contrast, the community nurse was satisfied with information sharing between himself and the pharmacist:

‘So I went in and asked could I get four weeks supply again and I would write on the boxes and I would bring back the half-used boxes, and they were more than happy. But I had to explain to the pharmacist why I was doing it, and the situation at home and the patient’s illness, symptoms and so forth. So I was sharing information with the pharmacist, but I had to, because the pharmacist would rightly say we are giving you double prescription? So yes, I share information’ (community nurse).

Information sharing between pharmacists and nurses was inconsistent; pharmacists in particular thought that it could be improved.

Integration There were some direct references to the level of integration with the community health teams. For example, pharmacist 6 did not feel integrated in the health team; she discussed joint working and having a good relationship, but asserted this fell short of integration:

‘We work quite closely with our GP colleagues and district nurses and practice nurses but we are not necessarily integrated. So we have good relations and we talk about joint interests, but when it comes to doing other things I think community pharmacy is neglected from that’ (pharmacist 6).

She illustrated the effect of this with an example:

‘One of my newly diagnosed dementia patients is in the care of her disabled husband, it is about making sure the networks are in place because if she is having problems then it is not just her we need to worry about. It is her and her husband, and community pharmacy is perfectly placed to have that knowledge about what is going on’ (pharmacist 6).

It is notable that the pharmacist referred to the patient as ‘my’, which suggested ‘ownership’ of or relationship with them. This echoed the view of situated interaction (Burns 1992), emphasising pharmacists’ interaction with patients.

Pharmacist 7 also suggested that pharmacists could support carers of people with dementia:

‘It was like the woman this morning and it is her mum, just a stressful time really, and we are seeing more and more patients coming in and they have been prescribed antidepressants and a lot of that is because they are carers for elderly parents – so we have got the whole family there we can support through that’ (pharmacist 7).

The community nurse described his routine working between the GP and pharmacy, suggesting the community pharmacist was an integral part of the community team:

‘Yes, they are always very accommodating. They know who I am. If I am going in to pick up medication it is usually because there is a problem,
as in the GP wrote the prescription. I asked him to write something and by the time he has written the prescription and it gets to the pharmacy, I have changed my mind or the situation has changed and I have had to change the drug, so there are alterations needed. So that is usually why I am there and I have never had any problems’ (community nurse).

The nurse continued by describing how he made contact with the community pharmacists to seek support with his role as an independent prescriber:

’So I chose to make contact with all the pharmacies in my area. That was something I did when I was doing my prescriber training. It makes sense because you are going to be writing prescriptions and the pharmacists are going to be getting these prescriptions and they will be thinking, who is this from?’ (community nurse).

Discussion
The communication between community pharmacists and community nurses was reported as being inconsistent in this study. When people work effectively in a network, each individual must have a relationship with others in the network (Zhao and Elesh 2008), and to do this they have to communicate. The pharmacists all communicated well with the community nurses, which was substantiated by the participant who was a community nurse.

However, a number of glitches arose in communication between members of the healthcare network, including community nurses’ lack of understanding of the amount of work involved in matching prescriptions and providing dosette boxes. Additionally, the community nurse in the study was unaware of the extent of pharmacy technicians’ role in supporting the pharmacists’ work.

Information sharing between pharmacists and nurses was variable. The pharmacists suggested that at times it was good, but it was affected by other factors. For example, one GP practice may have several community nurses working with patients attending that practice. This is because community nurses may be based diversely in the community, perhaps in health centres and hospitals. The same GP practice may also be working with several community pharmacies. This type of localised rather than centralised health professional situation means an effort has to be made to share information. This may support the notion that there are structural holes in the network (Granovetter 1973) caused by localised working. When networks work well, patients receive an optimal service. By contrast, when they are not functioning so well, then patients may be less well supported. For people affected by dementia this may be problematic. Jones et al (2004) suggested better interaction was needed between health professionals to improve information sharing, and technology was one way to achieve this (Jones and Thomas 2007).

Pharmacists did not feel integrated in the healthcare team and provided evidence to demonstrate this. In contrast, the community nurse asserted that he considered the community pharmacy as part of the community healthcare team and provided examples of integrated working. Kadushin (2012) discussed how there must be cohesion in networks for them to be effective. It may be that the community nurse, because of his position as a prescriber, experienced cohesion with the pharmacists. The nurse had taken on part of the pharmacist’s role by being involved with medicine, but there was no reciprocity because there was no scope for the pharmacist to take on part of the nurse’s role.

Hudson (2006) discussed how shared identity could cause issues between professionals; in the face of this, the nurse in this study had made himself akin to the pharmacists, using prescribing to his advantage. In his view the pharmacists were integrated with the community healthcare team. The pharmacists thought that collaboration with other health professionals was good but that it stopped short of full integration.

Additionally, they suggested that integration with other health professionals would benefit the carers of people with dementia. The example was given of a carer being supported with antidepressant medication.

This type of interaction between the community pharmacist and carers demonstrates the application of situated interaction (Burns 1992). The pharmacist focused on the individual needs of carers. The pharmacist was able to support this carer with medication, but if they were a fully integrated member of the healthcare team they would also be in a better position to liaise with other professionals to supply additional necessary support. The Scottish Government (2013) has recognised the need for collaboration between community pharmacists and other health professionals and is driving it forward.

A limitation of this study is that it was derived from a larger study, and only used the views of one community nurse. The larger study was concerned with finding out about pharmacists’ experiences when supporting people affected by dementia. The health professionals were interviewed to provide insight into how they viewed the pharmacists. The study was based on the viewpoint of one nurse and seven pharmacists so the research may not be
generalisable. Further research with a larger range of participants is needed to explore the interactions of community pharmacists and nurses supporting people affected by dementia.

Conclusion
Communication between community pharmacists and community nurses can be problematic (While et al 2005). Despite this, participants in this study have shown this need not be the case; that there is potential for community pharmacists and nurses to have good communication. Sharing information was difficult at times and this may have been exacerbated by localised working arrangements; increased use of technology may help with this. Integration in the healthcare team was seen as a future goal by the pharmacists while the nurse intimated that pharmacists were already an integrated part of the team. These are hopeful viewpoints; there is potential that pharmacists will feel integrated as part of the community healthcare team in the future and be able to augment support for people affected by dementia. This viewpoint is supported by government policy (Scottish Government 2013).

A larger study is recommended involving more nurses and with the primary aim of exploring interactions between community pharmacists and nurses providing support for people affected by dementia.

References


