Supporting health care professionals in three clinical settings to engage in Advance Care Planning (ACP)

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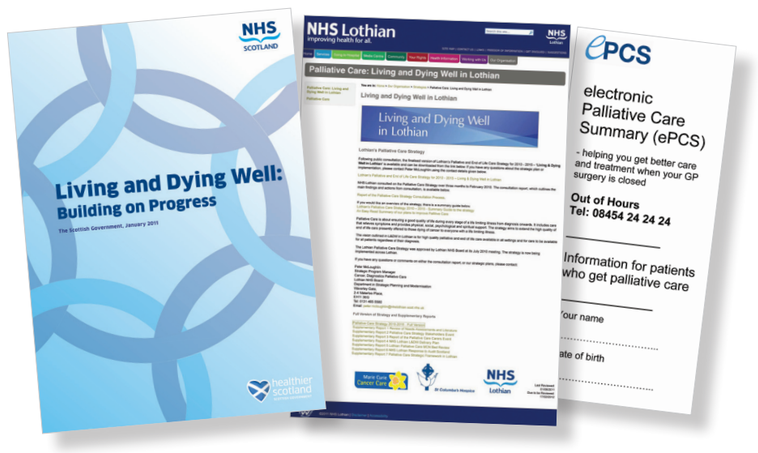
Introduction

Living and Dying Well: Building on Progress[(1)] and NHS Lothian's Palliative Care Strategy 2010[(2)] recommend a "thinking ahead" philosophy (ACP) for all patients in the palliative phase of an illness and outcomes shared electronically using the electronic Palliative Care Summary (ePCS)[(3)].



Advance Care Planning is a process of discussion between an individual and their care provider about their preferences, wishes, beliefs and values about future care. Its purpose is to provide guidance to inform future care decisions in the event that the individual has lost capacity to make these decisions.

An Anticipatory Care Plan is a dynamic clinical document used by and for care staff which provides a record of the preferred actions, interventions and responses that care providers should make following a clinical deterioration or a crisis in the individual's care or support. NHS Lothian recommends healthcare professional use the ePCS as an anticipatory care plan.

(NHS Lothian Palliative Care Strategy, 2010)

Aim of project

A one year collaborative project between NHS Lothian, Marie Curie Hospice Edinburgh and St Columba's Hospice aimed to identify ways to support the implementation of ACP in three clinical settings within Lothian.

Setting details:

Setting 1 – Two social care homes (66 beds) for older people many with dementia

Setting 2 – 18 bedded acute stroke unit in university hospital

Setting 3 – GP practice covering a population of 9,000

Method

Champions were identified in each setting to work collaboratively with the project lead to optimise engagement, learning outcomes and future practice development.

In each setting the project:

- Used a learning needs analysis to identify learning objectives
- Delivered ACP education
- Developed an educational resource for the champions which included an ACP presentation, DNACPR DVD and ACP quiz
- Evaluated the learning outcomes

> "I feel I have gained a lot of confidence and would be quite comfortable to discuss and participate in related matters in the future" (setting 1)

> "I am now starting to think about ACP and where it fits with the patients I see" (setting 2)

Although the identified learning objectives were the same in each setting *(Table 1)*, the educational approach was adapted for each setting for a number of reasons including:

- Difficult to release staff from a busy clinical setting to attend workshops
- Lack of awareness of relevance of ACP
- Staff overwhelmed by new initiatives
- Project time frame limited

Table 1: Learning objectives

- **Define what is meant by Advance Care Planning**
- **Start to explore who may benefit**
- **Describe what Advance Care Planning may lead onto**
- **Be aware of the clinical tools (ePCS etc) used in Lothian to record and share the outcomes from Advance Care Planning discussions**
- **Explore your role and reflect the process in their setting**

Learning outcomes were evaluated in a variety of ways including:

- Workshop questionnaire (care home only) *(Figures 1-3)*
- Interviews (all settings)
- Evaluation questionnaire (setting 1 and 3)
- Review of ePCS activity (setting 1)

> "Staff have an increased understanding of what advance care planning and the anticipatory process means for residents in a care home" (setting 1)

Results

The learning needs analysis from each setting identified:

- Limited understanding of ACP, terminology and identification of palliative patients
- An informal unstructured approach to the process
- Perceived barriers to the practice of ACP

Figure 1: Workshop question 1 – How confident are you that you understand what is meant by Advance Care Planning?

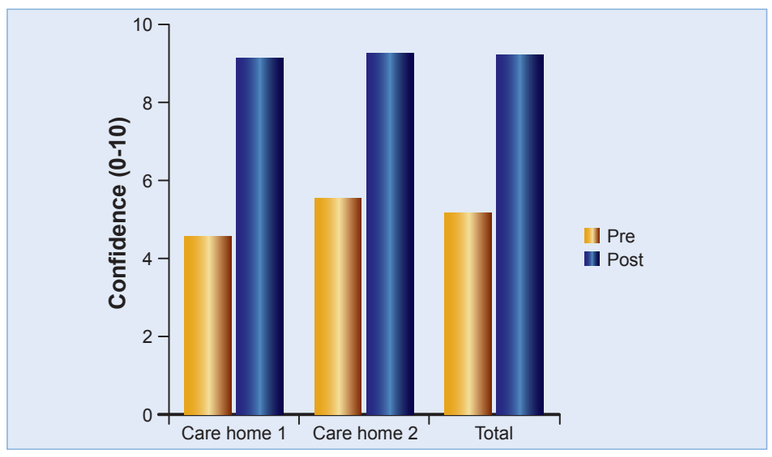


Figure 2: Workshop question 2 – How confident are you that you could identify who might benefit from Advance Care Planning?

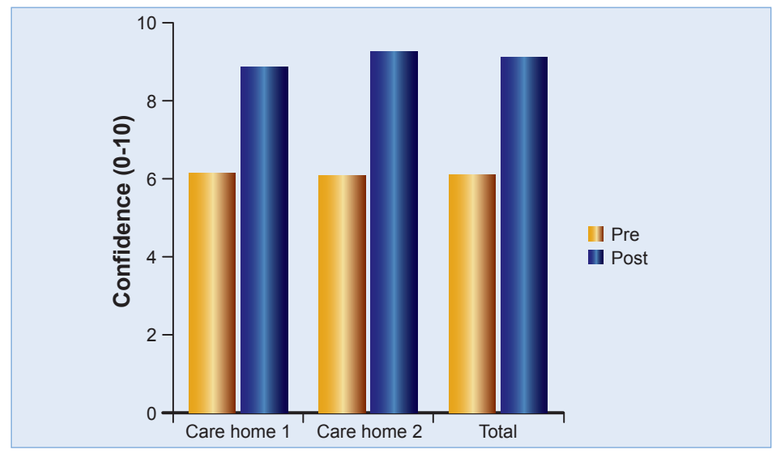


Figure 3: Workshop question 3 – How confident are you that you know where findings from an Advance Care Planning discussion should be recorded?

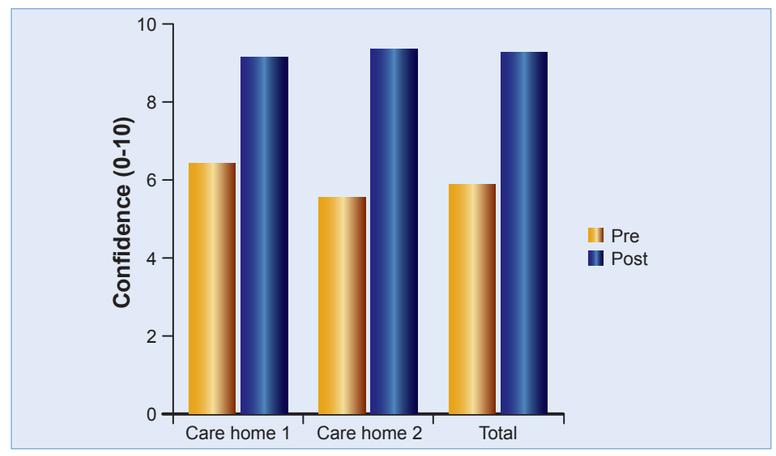
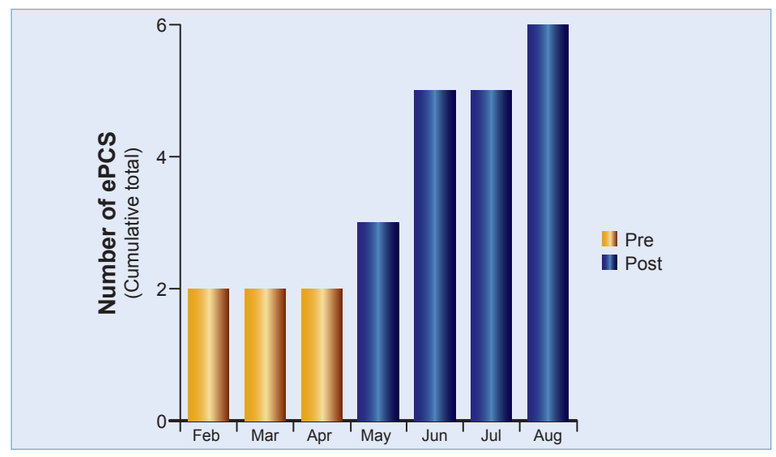


Figure 4: ePCS activity from primary care team attached to care home in setting 1



Evaluation identified:

- Increased staff awareness and understanding of ACP and the process
- A commitment from champions in each setting to review their current ACP processes and make improvements in collaboration with their teams

Conclusion

This project established successful educational approaches to support the implementation of ACP in three different clinical settings. These educational approaches may translate to other clinical settings with further facilitation and support. Further evaluation such as ongoing ePCS monitoring would provide valuable information relating to the longer term impact on patient care.

> "Understanding how the ePCS works now allows us to share information and hopefully enhance the care we give to our patients" (setting 3)

REFERENCES:

(1) Scottish Government. 2011. Living and Dying Well: Building on Progress. Available at: http://www.scotland.gov.uk/Publications/2011/01/27090834/0

(2) NHS Lothian Palliative Care Strategy. 2010. Available at: http://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/ladwinlothian/Pages/default.aspx

(3) Electronic Palliative Care Summary. 2010. Available at: http://www.scimp.scot.nhs.uk/ePCS.html