Improving Anticipatory Care Planning in Palliative care

EF-29

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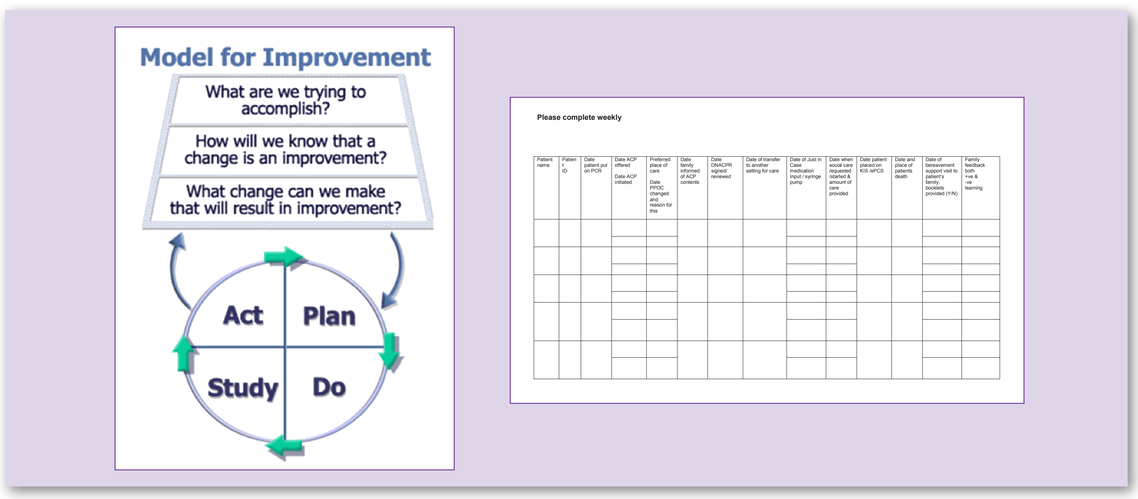
Introduction

Every year in Scotland 54,000 people die and its estimated 44,000 people should have had access palliative care. Anticipatory Care Planning (ACP) is an important national strategic aim (Scottish Government, 2015) and it provides people with a passport for discussing and documenting their wishes for care.

In NHS Ayrshire & Arran ACP's are encouraged but no data is available in community nursing as to how much of an impact ACP's have when the person is receiving palliative care.

One community district nursing team was approached. Training records in communication skills and ACP were up to date. The small team were willing to learn and use the model to improve practice and care for the patients they supported with palliative care. These patients were identified from the Practice's Palliative Care Register (PPCR). Of the 18 patients on the PPCR 1 had a completed ACP and 6 others had been involved in initial conversation about ACP.

Together an Aim was set–to have 95% of known palliative patients offered an opportunity to discuss their prognosis and preferences for care in one community district nursing team for 6 months.



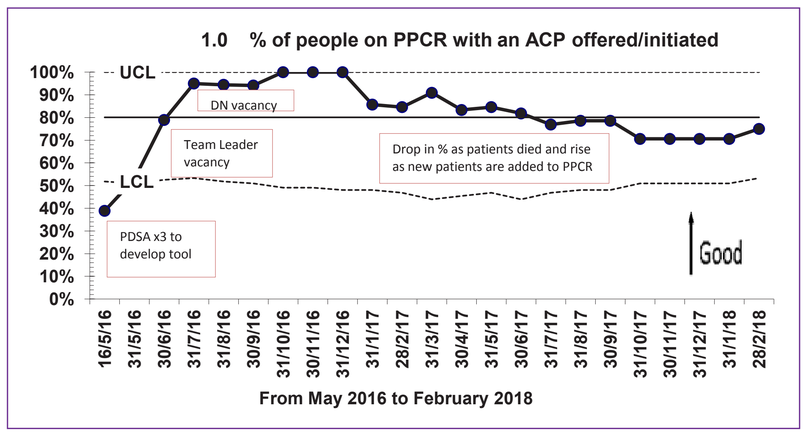
Methodology

Using the model for improvement and Dalry community district nursing team, a monitoring tool was developed. This showed all the identified patients on the practice palliative care register (PPCR).

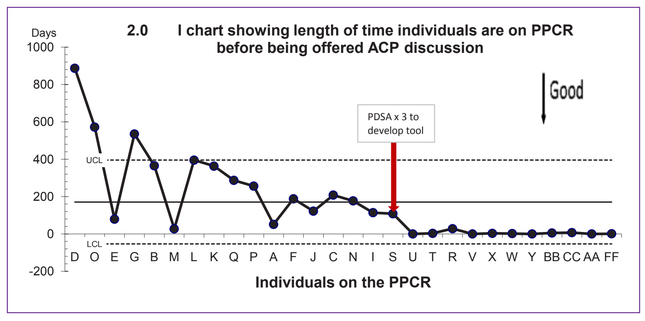
Data was collected that was measureable. This included when the person was placed on the PPCR, when they had been offered to discuss their care, their preference for place of care and when they died the date including their place of their death.

Evidence of improvement

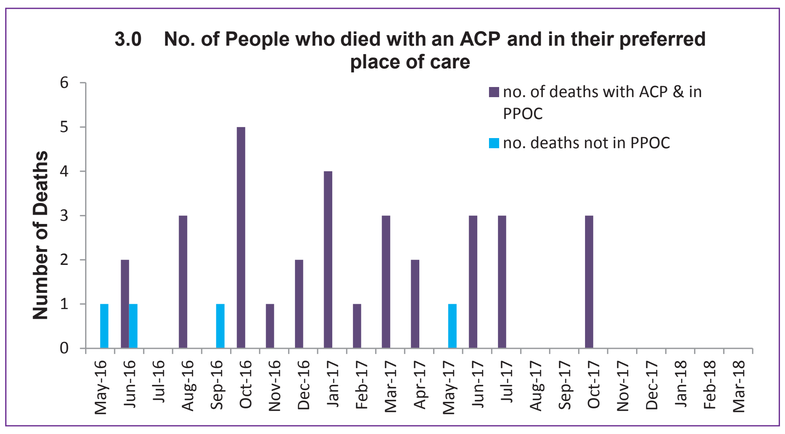
People with palliative care needs in this practice are identified and their care is reviewed by the community district nursing team where they are offered the opportunity to discuss their future care, treatment and preferences/wishes. This information is shared with other multi professionals via the GP electronic system and at the monthly practice meeting. This team began their improvement work in May 2016 (Illustration 1.0) and despite changes in leadership/management they have sustained ACP discussions with people being placed on the PPCR for longer than 6 months.



As a consequence of monitoring people on the PPCR the length of time from being placed on the PPCR till discussing their care and ACP was significantly reduced (Illustration 2.0).



Outcome- the community district nursing team recognise the importance of ACP discussions and the significance of people disclosing their heartfelt desires and wishes concerning their care in their locality. As a result of their improvement work, people died in their preferred place of care (Illustration 3.0). This was achieved for 32 people and 4 other people were admitted to hospital before their preferences where known or they had declined to discuss their wishes.



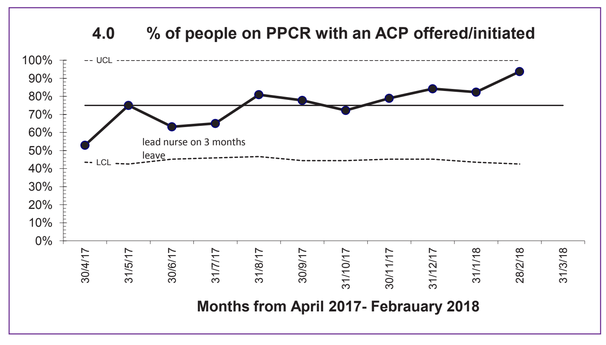
Key Improvements

- People on the PPCR monitored by the District Nurse team monthly
- DN actively informing practice of newly identified people with palliative care needs earlier
- People on the PPCR offered an ACP discussion earlier.
- Maintenance and spread of this work to other areas.

Another community district nursing team in North Ayrshire Health & Social care Partnership are using improvement methodology to improve the uptake in the uptake of ACPs with people who have been identified with palliative care needs.

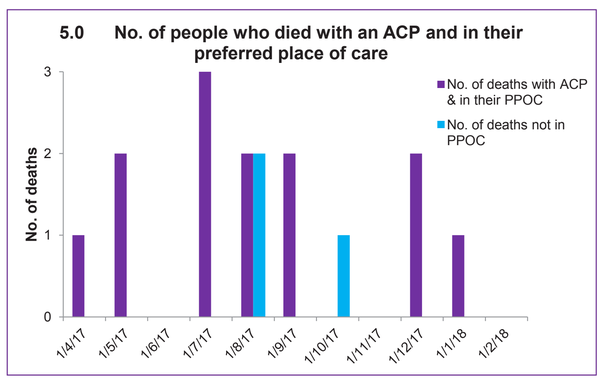
Community District Nursing Team Beith

The same Aim and Methodology and tools were used to collect measureable data.



Evidence of Improvement:
Although this team had light touch Quality Improvement support they are steadily showing improvement (Illustration 4.0):

A third team in North Ayrshire are beginning to collect data for improvement and it is anticipated that the Aim and Methodology shown here will be spread to the other community district nursing and health and social care teams in Ayrshire & Arran in 2018.



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References:

The Scottish Government, Strategic Framework for Action on Palliative and End of life care (2015) http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc/SFA