Advance Care Planning Project

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Collaborative Project & Presentation

- Background to the Project: Margaret Colquhoun
- The Project: Jackie Whigham
- Going Forward: Peter McLoughlin

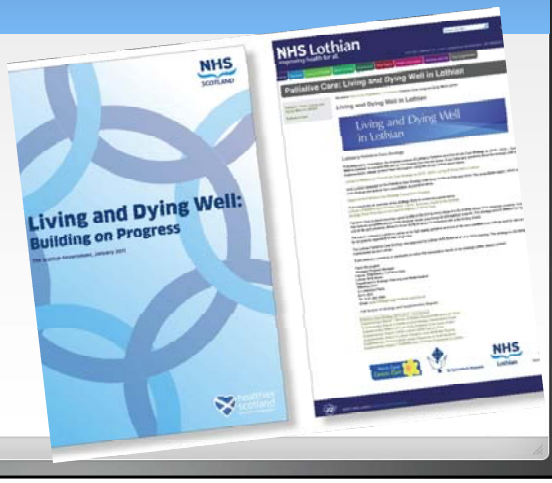
The Context: National/ Local Strategy (1, 2)

Set up systems to:

- Identify those needing palliative /end of life care
- Assess, plan, implement and communicate care

This requires staff to:

- Engage in complex conversations including ACP discussions
- Communicate those discussions to others



Aim of the Project

Funding secured for a project in Lothian to:

- Support health [and social care] staff to implement Advance Care Planning [ACP] using an integrated education and practice development approach

Facilitating change, delivering education, promoting communication between strategic management and clinical staff, responding to policy/ guidelines (3)

The Project Objectives: Develop the Lothian Approach to Advance Care Planning (ACP)

- Agree the definition
- Review the literature
- Collaborate with stakeholders and those leading other initiatives relevant to ACP
- Select three clinical settings to undertake more in-depth facilitation of staff to develop ACP as examples of good practice
- Engage with other health care professionals

The Educational Intervention – Clinical Settings

- Setting 1- Two Social Care Homes for older people
- Setting 2 – An Acute Stroke Unit
- Setting 3 – Primary Care Practice

The Educational Intervention – Defined Learning Needs Analysis

Table 2: Educational gaps identified during the specific learning needs analysis
• ACP terminology
• Palliative care definitions familiar to Specialist Palliative Care
• Identifying palliative patients/residents who may benefit from ACP
• The process used to record and share clinical information for patients with palliative care needs

The Educational Intervention – Educational resource

Table 4: Educational resource
• ACP Presentation, Appendix 6
• ACP Quiz, Appendix 7
• DNACPR DVD[18]
• Reference list (page 33)

The Educational Intervention – Learning Objectives

Table 3: Core ACP Learning Objectives
• Define what is meant by ACP
• Start to explore who may benefit from ACP
• Describe what ACP may lead onto
• Discuss the tools used in Lothian to record and share the outcomes from ACP discussions
• Explore their role and reflect on the ACP process in their setting

Workshop Model

A blended educational approach which included:

- **Completion of Project Learning Contract**
- **Pre and post workshop meetings with the champions**
- **Weekly workshops delivering the agreed learning objectives over 4 weeks**
- **Evening workshop delivering agreed learning objectives in one session**

Workshop Model

- Explored the benefits of a "thinking ahead" approach
- Identified barriers to ACP
- Explored how to change practice and implement ACP
- Identified various time points for ACP discussions:
  - On admission
  - When there was a change in the resident's physical condition or function
  - When the resident's care was being reviewed
  - During a GP review appointment
  - When a resident initiates a discussion
- Explored the information sharing process between health and social care

Tools

Poem –

Listen by anonymous

Marie Curie Cancer Care

St Columba's Hospice
MAKING EVERY MINUTE COUNT

NHS Lothian

Evaluation – Change in Practice

Case study 2: Example of change in practice

A member of the team described how a female resident often voiced concerns about dying, particularly during the night. Staff usually soothed her with a cup of tea.

Following the ACP workshop where the poem Listen, Appendix 8, had been played the social care worker reflected on how perhaps staff blocked an opportunity for the resident to discuss her beliefs and wishes.

The next time the resident voiced her concerns the social care worker made her a cup of tea and went to sit with her and said *"Tell me what is troubling you?"* As a result, the resident disclosed that she felt her life was coming to an end and that although she was not afraid of dying, she was afraid of being on her own as she did not have any family. The social care worker, after listening to her concerns, acknowledged them and reassured her that when the time came the team would do everything in their power to ensure a member of staff was with her at the end of her life.

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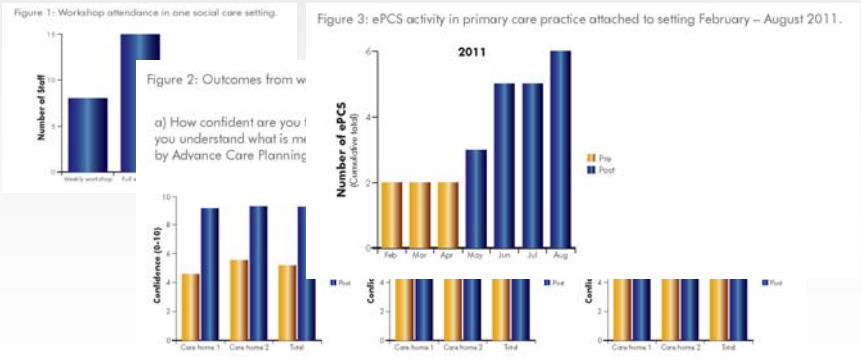
Educational Evaluation – Setting 1



Staff Evaluation

"Staff have an increased understanding of what advance care planning and the anticipatory process means for residents in a care home"
(Care Home Manager)

"Staff have started to ask questions about advance care planning for the residents during clinical supervision"
(Senior Member of Care Home Team)

Educational approach – Setting 2 & 3

The model was adapted in setting 2 & 3 and included:
- **One to one/small group discussions using a question and answer approach**

Table 6 Example of questions used during one to one/small group meetings
• Can you tell me about your understanding of the term "palliative care"?
• Do you currently practice advance care planning?
• Do you feel advance care planning using the definition I have described fits with your clinical practice in the stroke unit?
• Can you describe the challenges to advance care planning discussions in your clinical practice?
• Are you aware of any tools used in primary care to record the outcomes from advance care planning discussions?

- **Attendance and discussion at MDT/primary care meetings**
- **Adapted workshop**

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Engagement with Stakeholders

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RECOMMENDATIONS

1. Recommendations for MCN Educators

Develop a planned approach to:

- Incorporating ACP and palliative care education within social, acute and primary care undergraduate and postgraduate education
- Accessing ACP resources identified within the ACP project
  e.g. NES educational resource[22], National End of Life Care Programme resource[23,24]
- Novel approaches to embedding ACP education within clinical settings
  e.g. learnPro module on NHS Lothian's educational site

2. Recommendations for NHS Lothian

Develop a planned approach to:

- Identifying patients with palliative and supportive care needs using recognised tools
  e.g. Prognostic Indicator Guidance tool (PIG)[3] Supportive & Palliative Care Indicator Tool (SPICT)[4]
- ACP education for health and social care staff e.g. communication skills
- Training primary care staff to use recognised IT systems e.g. Electronic Palliative Care Summary[9]
- Promoting collaborative sharing of ACP outcomes with other health and social care teams

3. Recommendations for Clinical Settings

Develop a planned approach to:

- Collaborative review of ACP practice on a regular basis e.g. case review of good practice and how things could be improved
- Defining patient outcome measures for ACP e.g. ePCS activity

On behalf of ACP Project Thank you to all the staff who contributed

NHS Lothian Advance Care Planning Project. Available at:

http://www.nhslothian.scot.nhs.uk/MediaCentre/Publications/ForProfessionals/Documents/AdvanceCarePlanningReport.pdf

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Going Forward:

We need to respond to two main challenges in Lothian

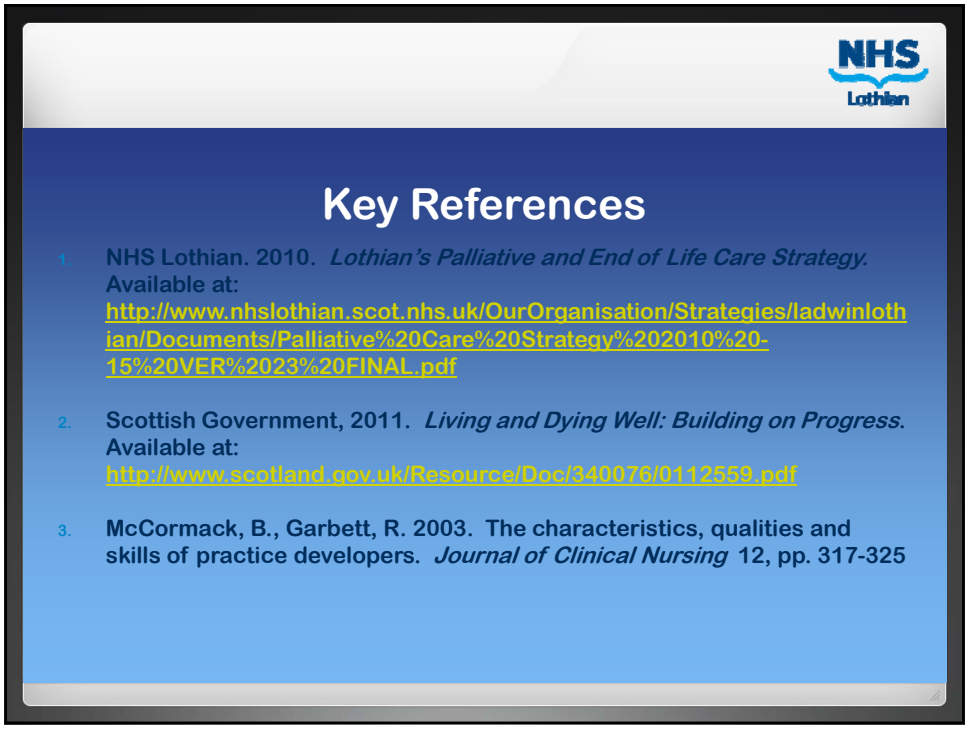
- How best to support effective Advanced & Anticipatory Care Planning across the service
- How to Keep it Simple

Strategic & Operational support:

- Maintain a focus on supporting use of the ePCS, and the DNAcpR policy
- Continue to develop the use of identification tools such as the SPICT
- Develop a more coherent and standardised approach to ACP in Lothian

Strategic & Operational support:

- Take advantage of new opportunities - the KIS (Key Information Summary) system – being developed by NSS
- Build on experience with Care Homes – LES for Anticipatory Care Planning / Marie Curie work with Midlothian Care Homes
- Build ACP & better Care Co-ordination into service redesign plans in Lothian
- Support through Education programmes / JIT opportunities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Key References
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