Evaluation of the ACP process in a demonstration site in North Ayrshire

Josaleen Connolly, Clinical Improvement Practitioner Cancer & Palliative Care; **Dr Stuart Milligan**, Lecturer, School of Health, Nursing and Midwifery, University of the West of Scotland and Education Facilitator, Ardgowan Hospice, Greenock; **Elaine Stevens**, Lecturer in Cancer and Palliative Care University of the West of Scotland and Education Manager, Ayrshire Hospice, Ayr; **Susan Jackson,** Lecturer in Cancer & Palliative Care University of the West of Scotland and Accord Hospice, Paisley; **Professor Kevin Rooney**, Consultant in Anaesthesia & Intensive Care Medicine, Royal Alexandra Hospital, Paisley and Professor of Care Improvement, Institute of Care and Practice Improvement, School of Health, Nursing and Midwifery, University of the West of Scotland. **Ann Gow**, Associate Nurse Director for Primary Care, NHS Ayrshire & Arran

NHS Ayrshire & Arran

Background

In 2008, NHS Ayrshire & Arran Hospital Standardised Mortality Ratio (HSMR) revealed that a high proportion (30%) of acute hospital deaths were of end of life patients. A further audit on deceased patients case notes revealed no evidence of any discussion for the person's preferred place of care in the case notes of 45 (88%) of admissions. In order to improve the quality of palliative and end of life care provision, NHS Ayrshire & Arran developed a demonstration site in North Ayrshire. The staff within this site were involved in Advance /Anticipatory Care Planning (ACP) training and development of documentation.

What is ACP?

The Advance Care Planning (ACP) process is part of a palliative care approach utilised for the discussion and documentation of personal wishes and choice for preferred place of care in the last days of life. This process can be used to anticipate need when the person at the centre of the care no longer has the capacity to make decisions about their future care.

Aim

To see if the ACP process would reduce avoidable admissions to the local hospital and to find out if the person's preferred place of care at the end of their life was achieved. The evaluation aimed to explore the impact of the ACP training and the effect this had on staff, changes in practice and patient outcomes.

Evaluation method

An evaluation team from the University of the West of Scotland were commissioned using funding from North Ayrshire's Reshaping Older People's Care Change Fund.
Nine semi-structured interviews took place, consisting of four with Care Home nurses, four with community nurses and one with a General Practitioner. Interviews were based on a pre-determined topic guide that covered three main domains.

Results

Impact on attitudes and behaviours of staff

The general consensus among all of the staff interviewed was that ACP was a worthwhile process.

"I think it IS worthwhile. I think it was something district nurses always did, but there was never anything officially documented or communicated to other agencies."

ACP was regarded as particularly beneficial in the event of admission to hospital when the document improved communication between home and hospital. In some cases staff stated that the ACP increased the likelihood that the returned to their home setting much earlier. Another respondent suggested that ACP had led to slightly fewer hospital admissions from home than before. The GP overall was positive about the ACP process:

"The document makes it easier to raise a difficult topic, then to leave it until the patient feels ready to discuss it"

Some care home staff felt less positive about the whole ACP process. They identified a number of practical challenges including:

- Problems with the documentation "not user-friendly"
- Reluctance of residents or family members to engage in the process
- Problems when discussing the ACP with staff outside the demonstration site
- Some resistance from doctors (GPs and out-of-hours)

All staff acknowledged that the formal introduction of ACP had led to changes in their practice. The specific ways in which this had happened were as follows:

- Take a more proactive approach and begin the process earlier

"Doing ACP with people with dementia before they lose capacity" [GP]

- Use the documentation as an aide-memoire
- Carry out the process in a way that involves and empowers residents and families

"ACP is also discussed at the residents meeting" [Care Home Nurse]

Nevertheless, several respondents made the point that they still exercised great caution.

"We can leave it with the person and go back another day to discuss it" [Community Nurse]

Many respondents varied in how likely they thought having a completed ACP would lead to a person being cared for in their chosen place.

"I think having the documentation is not enough. You also need to have conversations with colleagues (hospital staff, accident and emergency staff)" [Community Nurse]

"I hope that if they don't manage to die in their chosen place, then they would know that everything had been done to enable that and it has not been possible. And hopefully they will have been able to be cared for in their second choice."[GP].

Impact on self-reported behaviours of individual staff with specific regard to completion of ACP documentation

It was evident that some staff prioritised ACP more than the others. For those who had experienced a positive outcome with implementing ACPs this motivated further use of the document. The reasons given were dependent on individual circumstances and seemed to relate to relatively isolated cases. Other comments from care home staff hinted at more institutional barriers including:

"The ACP is not classed as a mandatory plan so it is not included in the admission documentation"

Care home staff could readily identify parts of the document which either were or were not regularly completed such as:

"The 'likely prognosis' box often gets left. I don't think nurses feel that is their responsibility."

The part most often omitted by community nurses was the DNACPR section. Reasons given included staff reticence, family reticence and the fact that this is the one part of the form which is often completed by someone outside the nursing team (the GP). Interestingly the GP also identified DNACPR as the aspect that was most likely to be missed:

"That is the hardest question to know when to discuss. It can get put off for various reasons. It is sometimes left until the professional perceives that the patient is "ready" to contemplate not having resuscitation".

All of the respondents recognised the seriousness of disregarding an individual's documented decision but they found it relatively easy to recall a situation where an ACP was not acted upon. The examples they cited tended to involve an admission to hospital (or some other medical intervention) near the end of life.

Impact on outcomes for individual patients

The final part of each interview asked about examples of cases where ACP was either successful (in terms of honouring a resident's end of life wishes) or unsuccessful. Many of the respondents provided numerous examples of where having an ACP to document the patients preferred place of care and end of life wishes enabled this to be achieved. Respondents gave reasons for why an ACP might not be acted on in Table 2.

Reasons why ACP is not acted on	
Duty of care	"If a DNACPR is not filled out, we still have a duty of care to follow. In the event of a cardiac arrest we would have to call 999. The ACP may say the resident doesn't wish to be admitted, but it will be disregarded in such instances"
Unmet care needs of the individual	"Their most relevant needs are what determine where they die. They will be where their needs can be met. They may be moved if the client's needs become more than we can provide"
Medical decision	"The GP may still feel a hospital admission would be of benefit. They think they have to try everything they can. They need to know they have tried everything"
Family uncertainty	"ACPs get acted upon when there is very clear agreement from the family. When there is less clarity, ACPs are not likely to be acted upon. For instance, if the relative is very anxious about the deterioration in the person's condition, you would have to choose hospital"

Table 2 Reasons why ACP may not be acted on

Other respondents provided their views on whether an ACP helped to prevent inappropriate admissions to hospital:

"A decision not to admit someone to hospital does not happen on the basis of the ACP. It happens on the basis of the discussion that staff have with the GP at the time" [Care Home Nurse]

"There have been quite a few end stage long term condition patients have stayed at home because we have had these conversations. We have done anticipatory care planning AND advance care planning." [Community Nurse]

Conclusion

Most participants expressed positive views about ACP although there was variation in attitudes. Some attitudes were certainly limiting the extent to which the formal ACP process was being carried out.

The process was influenced by a number of factors including organisational culture, local priorities, lack of time, own attitude and individual patient and family factors. Despite this, a number of changes in practice were identified and attributed to the effects of ACP training such as earlier discussions with people who would not necessarily have received it in the past (namely those with long term conditions, non-malignant diseases and dementia). Admission to hospital was in some cases prevented (or stay in hospital was shortened) by the presence of a completed ACP.

Staff within the demonstration site have a greater awareness of the importance of ascertaining patient choices with regard to hospital admission, the ACP documentation to record such choices and there are more proactive efforts on the part of professionals to avoid hospital admissions where this is contrary to the patients' wishes. Similarly several examples were reported where having a completed ACP seemed to lead to more appropriate decisions being made at the end of life and resulted in patients achieving their preferred place of death.

References:

The Scottish Government (2008) Living and Dying Well: A national action plan for palliative and end of life care in Scotland. The Scottish Government, Edinburgh.

The Scottish Government (2011) Living and Dying Well: Building on progress. The Scottish Government, Edinburgh.

Ref. NC13-00534