WHIPPS CROSS UNIVERSITY HOSPITAL, LONDON

Improving Advance Care Planning In A Hospital Setting

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Introduction

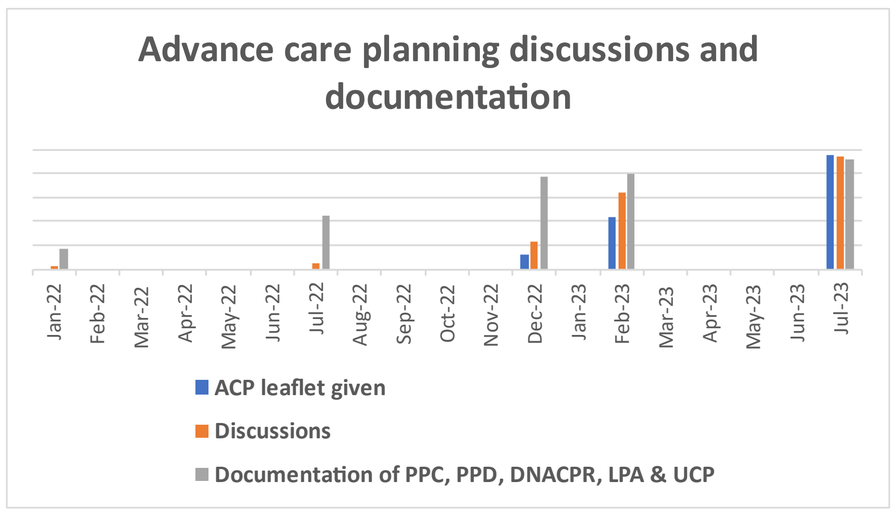
Everyone approaching the end of life should be offered the chance to create a personalised advance care plan. To improve advance care planning in the elderly wards involving 3 key steps:

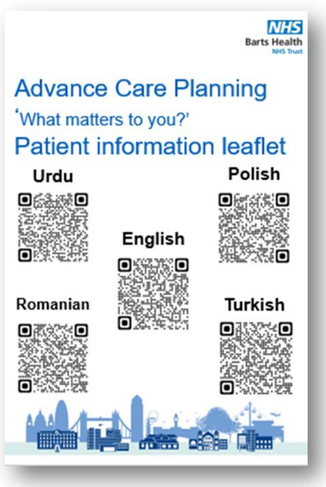
DISCUSS
- Initiating sensitive conversations around individual's values, wishes, beliefs, goals, and treatment preferences.

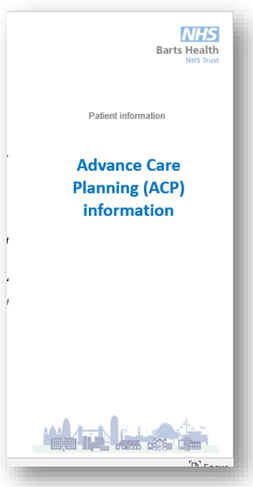
DOCUMENT
- Preferred place of care / death, lasting power of attorney, DNACPR, treatment escalation plan.

DISSEMINATE
- Primary Care (GP, DN), specialist palliative care nurses and urgent care providers via Universal Care Plan and GREAT template on discharge summary.

Results







Methods

On admission to the ward
- Welcome pack with advance care planning leaflet and an invitation to have these discussions by the admitting nurse. Translated leaflets available.

MDT and Board Rounds
- Discussion of holistic needs, patient preferences, DNACPR, TEP.
- Feedback on effectiveness of treatment and symptom control.
- For deteriorating patients, considering rapid discharge to preferred place of death.

Ward Round
- In depth discussion with patient regarding preferences of care and wishes.
- Consent to share information via Universal Care Plan (UCP).

Safety huddles and handover (doctors & nurses)
- Agreed escalation plans, DNACPR, patient preferences.

Family Meetings
- Preferences of care, share medical updates, address family concerns.
- For deteriorating patients, discussing rapid discharge to preferred place of death.

On discharge (doctors & nurses)
- Create or update Universal Care Plan (e-record)
- Create "GREAT" discharge summaries.

Make discharge letters for End of Life Care patients **GREAT** Barts Health NHS Trust

G GSF Code — Needs based coding to support proactive planning | Up to 12 months | Months to weeks | Days to hours

GSF code: If you think your patient may die in less than 12 months or sooner

R Resuscitation Status

Is a DNACPR in place? Make sure a copy is sent home with the patient and patient / family are aware. Create / update Universal Care Plan.

E End of Life Care Medications

If the patient may die in < 6 weeks consider prescribing anticipatory drugs as per intranet guidance and complete authorisation Pan London MAAR chart.

A Advance Care Planning

Let GP & Community services aware of any plans discussed by creating or updating Universal Care Plan

T Treatment Escalation Plan

Advise community teams of any ceilings of care. Would further hospital admission be of benefit or not?

Adapted from The Dudley Group, NHS

Conclusions

- Staff Impact: Exponential increase in written information given, discussions and documentations with shared responsibility as MDT engage in advance care plan discussions, promoting a comprehensive, holistic approach.
- Confident and Proactive: Staff members feeling more confident and proactive in initiating discussions and taking pride in participation, reflecting a commitment to patient-centered care.
- Community Collaboration: Improved collaboration with community partners ensuring a smoother transition of care.
- Patient Impact: Voice Heard: Discussions providing patients with a platform to express their wishes and values, promoting autonomy and having greater insight to progress.
- Family Impact: Transparency by fostering trust and reducing misunderstandings and complaints. Being better prepared for potential deterioration. Confidence in care increases with involvement in decisions.
- A consistent improvement demonstrated with increasing communication, collaboration, and overall care for both patients and their families.

"We didn't realise the impact of having Advance Care Planning and we didn't identify where our patients were on their disease trajectory. We are now more confident to have these discussions and create UCPs as a digital handover to community colleagues who can continue to align care with patient wishes."

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Role Of An End of Life Care Facilitator In Embedding The Gold Standards Framework

Author: Shanthini Avorgbedor, End of life care facilitator

Introduction

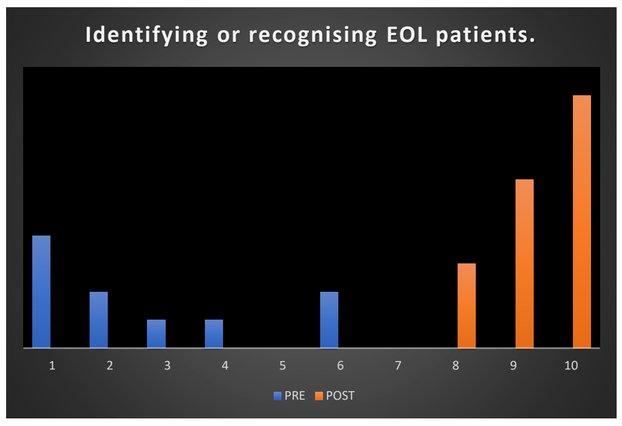
We embarked on an enthusiastic journey to implement the Gold Standards Framework (GSF) within three wards of our hospital. Dedicated GSF champions underwent training sessions led by experienced GSF trainers from 2020. Promoting confidence during the launch of a new initiative is vital for its successful adoption. The EOLC facilitator played a pivotal role in training, coaching and supporting staff. To support ongoing improvement, increase confidence, a routine schedule for regular teaching sessions and knowledge sharing was established, thereby promoting a culture of continuous learning and collaboration.

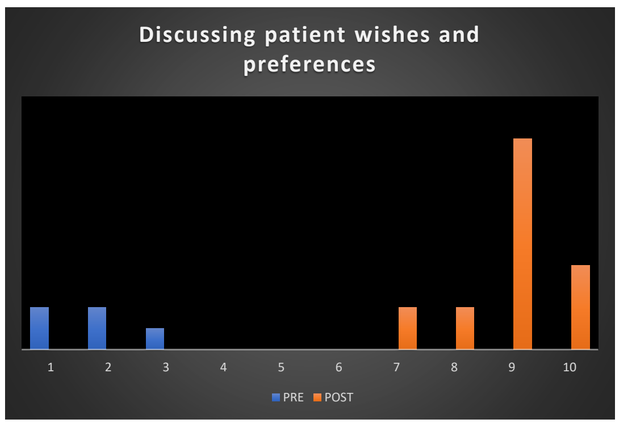
Methods

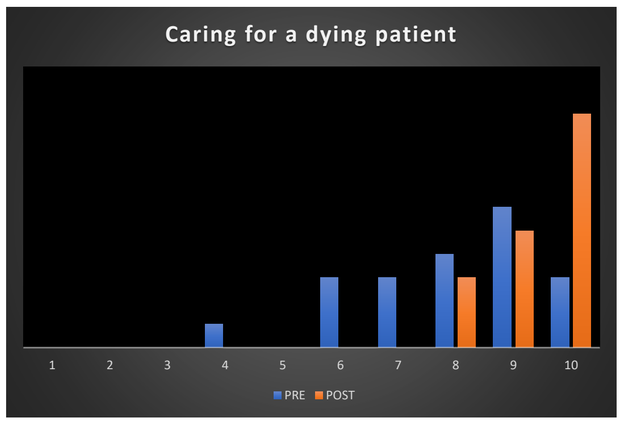
The training approach to introducing and sustaining the momentum of the initiative encompassed several methods:

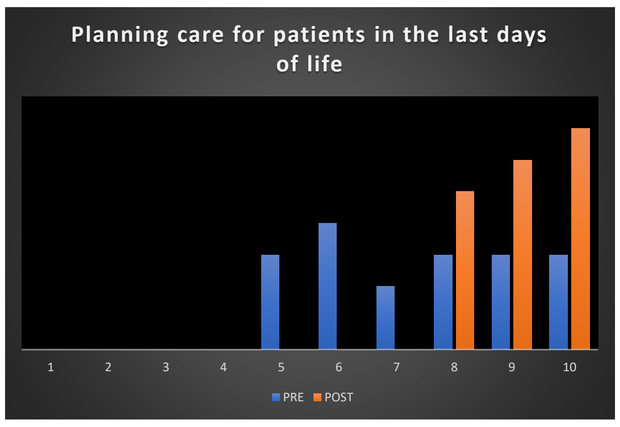
- GSF training videos were used for all staff and made conveniently accessible via the hospital intranet.
- Additional, face-to-face training sessions were conducted for the multidisciplinary team, fostering direct interaction.
- A series of regular workshops were held, contributing to continuous learning.
- Ensuring ongoing commitment, weekly and monthly coaching sessions were established with GSF champions on the wards.
- New team members were integrated through dedicated induction sessions, including when there was a rotation of junior doctors.
- Bi-weekly adhoc teaching during Ward board rounds.
- To target areas for enhancement, mini–Quality Improvement Projects were initiated, focusing on specific aspects eg: pain assessment.
- All staff were invited to complete a prequestionnaire using a QR code at the introduction of GSF and a post questionnaire done after embedding the programme to understand the impact of training in providing care for the end of life patients.

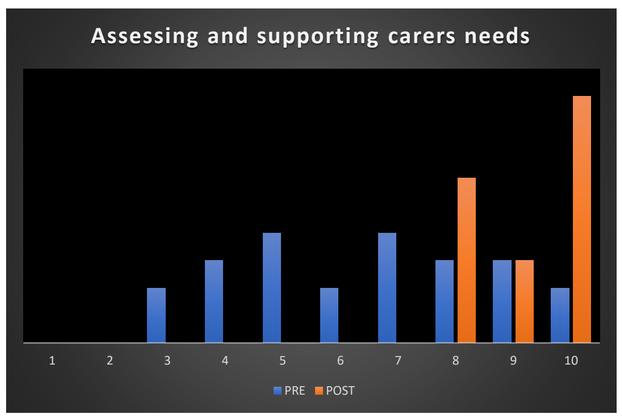
Comparison of confidence level of staff pre & post embedding GSF (on a Likert scale 1-10, 10 being most confident)

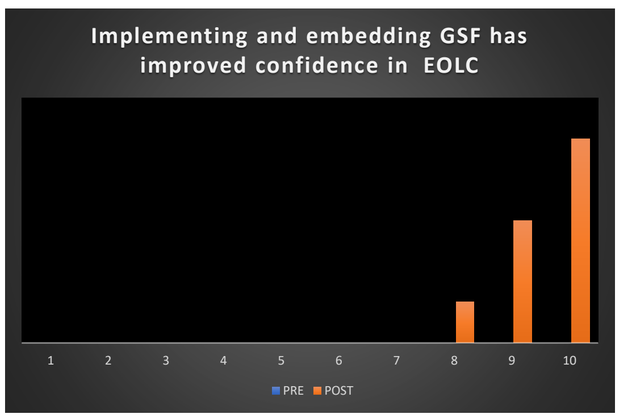


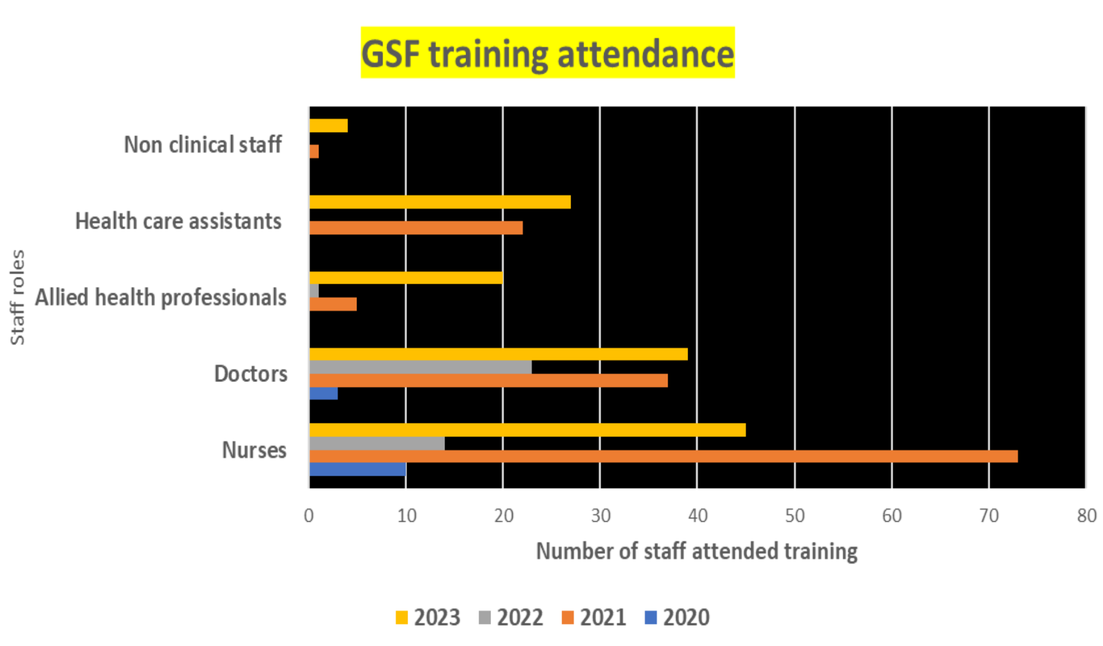












Conclusions

The training sessions yielded success by visibly boosting the confidence levels of staff across various grades. These sessions provided a platform to discuss apprehensions related to knowledge and attitudes when tending to end-of-life patients.

Notably, advance care planning, a previously hesitant area of involvement for staff, witnessed a transformation in their confidence and demonstrated remarkable adherence to the practice.

Another noteworthy outcome was the enhanced ability of staff to identify end of life patients and effectively integrate all facets of the Gold Standards Framework (GSF) into their routines.

"Regular GSF training built our confidence and competence by helping us to master the roles such as identifying end of life patients, discussing advance care planning, improving documentation and caring for patients and supporting their carers. It was a useful time to discuss the challenges we faced and brainstorm strategies to improve care."