END OF LIFE CARE

CASE STUDY

The Conversation Project

Empowering Royal United Hospitals Bath NHS Foundation Trust staff to feel more comfortable having conversations about the wishes of patients approaching the end of their life

Introduction

The Conversation Project shows the importance of earlier identification of approaching end of life, need for greater involvement in conversations with patients and families around decision-making, ensuring appropriate understanding and how this helps to make informed decisions about the future.

The project team, which included the specialist palliative care team, recognised when health care professionals accept that a patient is dying, they may feel comfortable with the care that they need to give, and more confident in their actions since the plan of care feels more certain.

However, the period of time prior to identifying a patient is in the last few days of life, is often one of great uncertainty and anxiety, for the patient, family and also for staff. The team felt this area of care, for their staff, was in greatest need of exploration.

The Conversation Project was originally developed by the Royal United Hospital with the Kings Fund Patient and Family Centred Care Programme (PFCC), to support patients nearing the end of life and their families/carers to have the opportunity to talk about their wishes, uncertainties and concerns as part of advance care planning, to then inform care planning. See www.kingsfund.org.uk/sites/files/kf/bath-poster-end-of-life-nov13.pdf

It has supported early identification of patients with end of life care needs in an acute setting, as well as communication and information sharing of discussions and decisions made across settings, to support care out of hospital.
Overview and approach

The approach taken was to collect evidence from clinical records, set up a working group, implement new ways of working and collect evidence to see if a positive change was taking place. Notes were reviewed on a regular basis and data collected. Selected data are shown in graphs 1–4 below. The palliative care team attended regular ward multidisciplinary team (MDT) meetings to ensure end of life care issues were included in the discussions and to act as a resource for staff.

The importance of having regular discussions with the patient and/or family, and recording the outcomes of discussions continues to be highlighted to the wards and is shared at the white board/MDT meetings.

- **Staff engagement** – small teaching sessions, one-to-one discussions with staff and staff questionnaires helped

- **Meeting the educational and training needs of staff** is an ongoing challenge and not easily achieved, but small pockets of training as at March 2015 have been carried out. The team continue to support all levels of staff in managing individual patient care

- **Sustaining change** – the team worked with staff who were most motivated, then supported and benefitted from them as change agents. The team used evidence to show where positive change has happened

- **Maintaining motivation** – patient stories have been a motivating force.

Motivation has been maintained with a simple message. The team remain aware that change can take time.

Clinical record audit findings from April 2014 to March 2015

Apart from one month, all relevant records reviewed showed either a decision made by the MDT team that recovery for this patient is uncertain, or they may be approaching their end of life or likely to die in the next few days.

Audit evidence also showed when a patient did not have the capacity to take part in discussions about advance care planning or discussions at the end of life, the medical notes clearly evidenced this. At the time of writing there continues to be a higher percentage of this being recorded on wards for the older person and the acute stroke unit.

Where discussions with the patient have been recorded as not appropriate, there was evidence of discussion being held with the family/carer for the patient. This again was predominantly on wards for the older person and the acute stroke unit. From April 2014 to March 2015 all reviewed records showed evidence of a discussion with a family member unless the person had none. The 2015/16 audit will include more detailed questions if there has been no discussion with a family member.

The graphs below show the change evident from clinical audits:
Graph 1: Percentage of records with a clear medical plan

Note: data has been rounded to the nearest % so some columns may not add up to 100%.

Graph 2: Percentage of records with evidence of regular discussion with patient and/or family

Note: data has been rounded to the nearest % so some columns may not add up to 100%.
Graph 3: Percentage of records with a DNAR decision made or Ceiling of Treatment plan including DNAR

Note: data has been rounded to the nearest % so some columns may not add up to 100%.

Graph 4: Percentage of records with evidence of advance care planning information passed onto the Primary Health Care Team on discharge

Note: data has been rounded to the nearest % so some columns may not add up to 100%.

Where the audit identified ‘not applicable’, this was because the patient died in hospital. A number of records identified no evidence of information on advance care planning being passed on to the Primary Health Care Team on discharge, shown as ‘No’ in Graph 4 above. This is highlighted with the wards and information shared at white board/MDT meetings.
Spreading positive change

The Conversation Project was initially piloted on just one ward. Once this was felt to be working the project extended to a further five wards in 2013/14. In 2014/15 a further three wards had begun to implement the work. The plan is to adopt the themes of The Conversation Project as part of normal ward practice across all ward areas of the Royal United Hospitals Bath.

Patient experience

Measuring this can be a challenge. Identifying an opportunity to ask patients, when often they are very unwell can be particularly difficult. However the team do know that if patients have had the opportunity to express their wishes, and been involved in decisions about their care, then it is more likely that their wishes will be met.

There are benefits to patients to ensure that there is appropriate decision-making and potential to reduce length of stay as the focus of care becomes more attuned to the patient’s wishes.

Improving acute communication with primary care can enhance the coordination of care and help to ensure that appropriate care takes place.

Family experience

The project alerts staff to seek out families and be more proactive in their dialogue with them to ensure their questions are answered and concerns addressed.

From feedback from a small number of families about their experience of the conversations they had with health care professionals, all observed they valued the honesty and information they had been given.

Acute staff experience

Staffs’ positive enthusiasm and engagement with this work has helped the project embed as staff understand the importance of what they are doing and why. It is greatly important to staff to make sure they meet the needs of patients and families at end of life care. This work has helped staff feel that this can be achieved, they recognise it is an area that can be continually improved and, equally their role and responsibility within it.

General Practice experience

GP’s have welcomed information shared as part of discharge planning. Improving communication with primary care can enhance the co-ordination of care and help to ensure that appropriate care takes place.

Reflections and lessons learned

• Most advance care planning in the acute setting was consultant driven

• A greater multidisciplinary involvement in helping support patients and families as they approach the last phase of their life is beneficial

• Continual effort is needed to ensure advance care planning discussions are shared with relevant services

• A better collaborative approach between primary and secondary care and vice versa helps to improve patient care towards their end of life

• A focused project helps to identify areas of training and support that staff need

• Listening to the experience of patients and families can help to develop improved practice and services
Future development

The Conversation Project continues to grow and develop within the Trust, with the specialist palliative care team supporting a further five wards with implementation and nine wards with sustainability. In 2015/16 the Trust was also working with colleagues from the older person’s unit and dementia coordinators to develop The Conversation Project as a model to support conversations and advance care planning for patients with frailty or dementia. It is hoped the model will be embedded across the whole Trust, so that it becomes part of normal practice to support and enable patients and families to have conversations about their wishes for future care.

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