Advance Care Planning: Respecting patients’ wishes and healthcare choices in a nursing home setting in Aneurin Bevan University Health Board

Dr Clifford Jones, Macmillan GP Facilitator
Tanya Strange, Divisional Nurse Primary Care and Networks
Primary Care and Networks Division, Aneurin Bevan University Healthboard, Llanarth House, Newbridge Gateway, Newbridge NP11 5GH

Introduction:
It was identified locally that a significant proportion of Nursing Home (NH) residents were being admitted to hospital at the end of life, and that a major contributing factor to this trend was that their wishes regarding future and end of life care had not been established, and that the majority of NH residents did not have Advance Care Plans (ACP).
We want to support, encourage and empower patients to plan for the end of life, and increase the number of people with an ACP.
The project that developed from this was a multidisciplinary initiative to up skill the NH sector workforce, to enable them to improve the care of older people by supporting individual residents to plan and direct their own care as they approach the end of life.

Current State:
- The opportunity to complete an ACP is not routinely and proactively offered to NH residents
- Majority of planning takes place in final weeks/days of life
- Multiple professionals discuss individual aspects of future care with patients
- No formal approach to documenting and sharing patient wishes
- Staff lack confidence in initiating/having conversations about end of life wishes
- Lack of knowledge/skills regarding ACP and legal framework regarding decisions made in advance and mental capacity act

Aims of the Project:
- Identification –Patients who would benefit from ACP are proactively identified
• ACP is introduced on admission to Nursing Home
• Equality of service – irrespective of diagnosis
• Skilled Workforce – Health Care Professionals/Nursing Home Staff have the necessary skills to and are confident in facilitating ACP
• Documentation – ACP and patients’ wishes are documented/recorded accurately and consistently, and are readily accessible
• Sharing of information – Sharing ACP decisions with relevant parties is encouraged and facilitated by HCP

Benefits:
• Improved patient care and shared decision making
• Reduction in inappropriate hospital admissions
• Improved planning will aid effective allocation of resources
• Contributes to ABHB response to ‘Together for Health: Delivering End of Life Care’

The Plan:
• Core Team – Macmillan GP, Senior Nurse Care Homes, Complex Care Social Worker, OOH Nurse
• Session at Nursing Home Forum on DNACPR, MCA and ACP for NH Managers/Matrons
• Followed by training day for NH staff with supporting documentation/ online resources

Training Day:
• Topics:
  o Introduction to ACP
  o Mental Capacity: Introduction & Practical Tips
  o Palliative Care in ABHB – the Bigger Picture
  o Communication Skills for ACP
  o ACP: Putting it into Practice
• Contributors:
  o Macmillan GPs, Palliative Care CNS (Hospital and Community), OOH GP, Social Worker, Senior Nurse Care Home Governance
• Outcome:
- 40+ attendees from 20+ nursing homes
- Nursing homes now implementing proactive ACP process, using standardised documentation
- Audit and evaluation of implementation ongoing
- Training now being extended to District Nurses and Complex Care teams

**Supporting Documents:**

- Project Report for NHS Wales Awards
- ACP tool.pdf
- Evaluation Report of Training Day
- Report of ACP Implementation in Nursing Home X.docx

**wIPADS –** Advance Care Planning online Guidance, Resources and Document Library: http://wales.pallcare.info/ipads/ipads_1.htm