BACKGROUND:

- More than 360,000 people in England live in care homes. They experience high mortality and are more likely to have unplanned admissions to hospital.
- Advance Care Planning (ACP) is a way for individuals to express their wishes for future care. ACP reduces avoidable or unwanted admissions and relieves pressure on acute services.
- Current pressures in primary care mean some GPs do not have sufficient time to offer ACP to all care home residents
- We used Ageing Well funding to develop a pilot project offering proactive face-to-face ACP in care homes (NBT Care Home Interface Project)
  - 2.8 WTE frailty practitioners (pharmacist, physician associate, paramedic)
  - 2.4 WTE doctors (geriatrician, 2x GPSI Frailty, registrar)

AIMS:

1. To deliver systematic ACP at scale to care home residents in the Bristol, North Somerset & South Gloucestershire regions, through comprehensive geriatric assessments by a multi-disciplinary team
2. To develop a competency framework to evidence upskilling of healthcare professionals in advance care planning in frailty

OUTCOME MEASURES:

1. Number of residents reviewed (indicating number of ACP discussions) and the number of updated ReSPECT forms.
2. Achieve competency sign off for frailty practitioners (physician associate, clinical pharmacist, paramedic)

METHODOLOGY:

- Establish MDT
- Develop a competency framework
- Identify care home sites: high admissions to or deaths in hospital; GP self-referral; CQC referral
- Face to face focused comprehensive geriatric assessment including ACP discussion
- Document ACP on GP system + online ACP platform: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

REFERENCES:

● NHS England » Governance, patient safety and quality ● ReSPECT | Resuscitation Council UK ● Care homes and estimating the self-funding population, England - Office for National Statistics (ons.gov.uk) ● Mortality in older care home residents in England and Wales | Age and Ageing | Oxford Academic (oup.com) ● QualityWatch: Focus on hospital admissions from care homes - The Health Foundation

NHS North Bristol NHS Trust

Advance care planning in care homes:

A multidisciplinary approach

How did we demonstrate ACP competency?

Our frailty practitioners were trained through shadowing, supervised practice and structured support. The requirements mirrored those in a wider Trust-wide competency framework concurrently in development.

Requirements:

1. Demonstrate relevant clinical knowledge to make clinically well-informed and appropriate patient specific recommendations on CPR and treatment escalation
2. Demonstrate understanding of the legal and ethical issues raised during ACP in frailty, including assessment of capacity
3. Demonstrate appropriate verbal communication skills
4. Demonstrate appropriate documentation of discussions and decisions made

ReSPECT

Evidence was collected using a log book which included:

- Work-place based assessments (mini-CEX – direct observation in clinical practice)
- Reflective case-based discussions (CBD) focussing on ethical / legal issues
- Evidence of completion of internal trust E-learning ReSPECT training module

Log books were reviewed and signed off by a consultant geriatrician. Following sign off, all ReSPECT forms continue to be counter-signed by a senior responsible clinician as per best practice, however this is not required to 'validate' the form for clinical use.

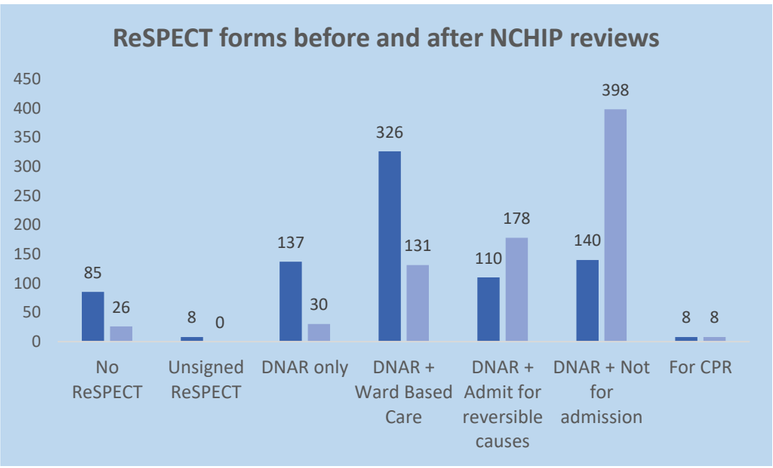
RESULTS:

Between February-August 2022, the team visited 20 care homes. 785 residents were reviewed, conversations with whom resulted in 416 new or updated ReSPECT forms.

All three frailty practitioners achieved competency to have ACP discussions and complete ReSPECT forms.

The proportion of ReSPECT forms with highly patient specific recommendations increased, with a shift from hospital-based guidance only to incorporating community escalation information.

- 78.1% decrease in ACP containing DNAR (do not attempt cardiopulmonary resuscitation) only
- 59.8% decrease in ACP containing DNAR + 'ward based care'
- 184.3% increase in ACP recommending admission avoidance



CONCLUSIONS:

Frailty practitioners can provide ACP in care homes. Ensuring thorough training, competency sign off, and ongoing clinical support is likely to be important for quality and governance.

- The intervention increased the number of residents with a comprehensive ACP providing specific treatment guidance of residents' wishes and priorities for their ongoing care.
- MDT inclusion in the ACP process was crucial to achieving outcomes
- Half of the residents asked no longer wanted to be admitted to hospital in the event of acute illness.
- Future analysis of the data could investigate the wider healthcare impact of the project's work, including impact on ambulance call outs and conveyance to hospital.

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