Published June 2022

Implementing Anticipatory Care Planning in Care Homes

Using quality improvement methodology to implement a new approach to anticipatory care planning in care homes.

This case study describes how Garscadden Burn Medical Practice (GBMP) successfully implemented a new anticipatory care planning (ACP) approach across two care homes. The project aimed to ensure that all residents had an ACP, and that this was shared with relevant health and social care professionals.

ACP is a person-centred, proactive approach to help people consider what is important to them and plan for their future care. Conversations between individuals, families, carers and the health and care professionals involved in their care are central to ACP.

> "Following my own experience of the care provided to my stepmother during her nearly three years as a care home resident, I am convinced of the value and benefit bestowed by clear-sighted, sensible and compassionate ACP."
>
> **Resident's family member, Almond View Care Home**

Background and Approach

GBMP, situated in Glasgow City, is a Deep End Practice, one of the 100 practices serving the most socio-economically deprived populations in Scotland. In 2015, GBMP became responsible for providing medical care to all residents within two care homes with 85 and 78 beds respectively. Dr Jude Marshall was appointed GP and lead healthcare professional for both care homes.

Dr Marshall identified the **need for each care home resident to have an ACP conversation** with appropriate documentation completed and **accessible to all health and care professionals** involved in the resident's care. Edinburgh Health and Social Care Partnership (HSCP) had recently been awarded an innovation prize from the Royal College of General Practitioners for implementing ACP in 20 care homes. Dr Marshall drew on the learning and tools from this work and adapted the process for GBMP.

1. Initiation of the ACP conversation process.

- ACP conversations were held **between the GP and existing residents and their family members**, ensuring that appropriate documentation was completed.
- A **new process was developed where nursing staff recorded ACP conversations** within the first four weeks of a resident's admission into care.

2. Training and case studies were provided to care home staff.

- **Informal training programmes** were developed with care home staff **on when and how to have an ACP conversation**.
- Care home staff were taught what to cover in these discussions to capture what matters to the patient and their family, and also to record what should happen if the resident were to become unwell.
- The training sessions also included **reflections on recent episodes of care in the care home**. Discussions focused on what did and didn't go well, and whether the resident's care may have been different if an ACP had been recorded.

3. Care home staff shadowed GP during ACP conversations.

- Care home staff had opportunities to learn about how to have ACP conversations by **shadowing the GP when having 30 minute ACP conversations** with residents and their families.

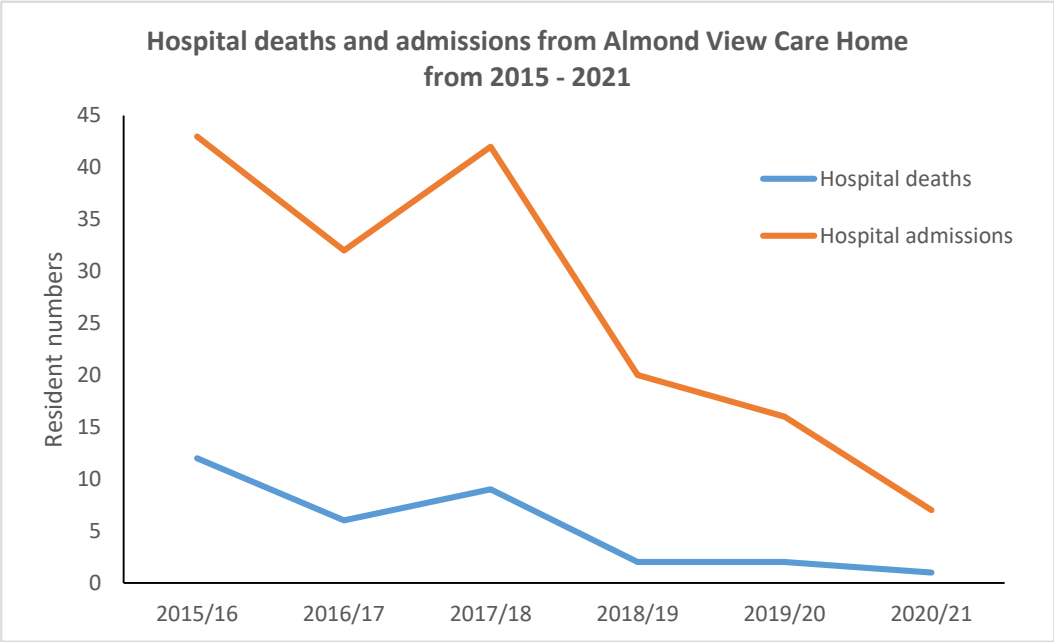
4. Care home staff took over carrying out ACP conversations.

- Experienced care home staff were subsequently **empowered to carry out ACP conversations alone** using **Edinburgh HSCP's** Anticipatory Care Planning questions for residents.
- Staff were supported by experienced managers who took on **the role of ACP champions** in the care homes.
- The GP was only asked to step in when care home staff anticipated an ACP discussion would benefit from their input with the resident and families.

Impact

- Residents **felt listened to and empowered** to share what mattered to them, and experienced better quality of care as a result.
- Staff experienced an increased workload initially to complete ACP processes. However, as the process continued staff reported **more confidence supporting** ACP, and **lower stress** in managing the care of residents who became unwell.
- Since implementing the enhanced ACP process, there has been a **decrease in care home resident admissions to hospital** and hospital deaths.

Hospital deaths and admissions data



The chart shows the impact of the enhanced ACP process since it was implemented in 2015 on hospital admissions and hospital deaths.

Please note: From January 2017 to January 2018 the programme was put on pause. Additionally 2020/21 data was impacted by the COVID-19 pandemic.

> "The GP relieved most if not all of the relatives' anxieties by giving appropriate information and answering any questions asked. They explained what we can and will do for their loved ones. Relatives were grateful for these meetings and I feel they had a better understanding of ACP and care of the elderly and the outcomes."
>
> **Service Manager, Almond View Care Home**

Top tips

- Be **aware of the initial workload** requirement for new ACP processes and plan accordingly.
- Encourage **engagement and confidence building** by letting care home staff take ownership of carrying out ACP conversations with the residents and families, and **shadow senior staff** handling more complex conversations.
- **Empower care home staff** to conduct enhanced ACP conversations with tools such as **training and simulated conversations**, consolidating their knowledge and skills. Embed informal education on ACP into everyday staff interactions.
- Complete new ACP conversations and documentation within an **agreed timeframe**, and undertake **regular reviews** for any outstanding processes.
- Have a system in place to **communicate ACPs to all relevant parties**. A copy of the ACP should be kept in residents' care plans, and the GP should **use Key Information Summaries** to share the ACP with all those involved in the residents' care.

Keep in touch @SPSP_PC his.pcpteam@nhs.scot