Improving Advance Care Planning Completion in Primary Care

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CQ, Patient Centredness
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Introduction

Advance care planning (ACP) is a patient-centred discussion involving the patient, family, and healthcare professional to ensure future care aligns with patient wishes. In Wales, this includes two recognised documents for those with capacity, and a best interests form for those without. ACPs in the elderly population have been shown to enhance quality of life, communication, and reduce unwanted hospital admissions. Studies show that ACP's are often not accurately recorded.

Objective

This project aimed to improve ACP completion in primary care at Penylan House Care Home and Roath House Surgery.

QR code: ACP documentation, NHS Wales

Case examples

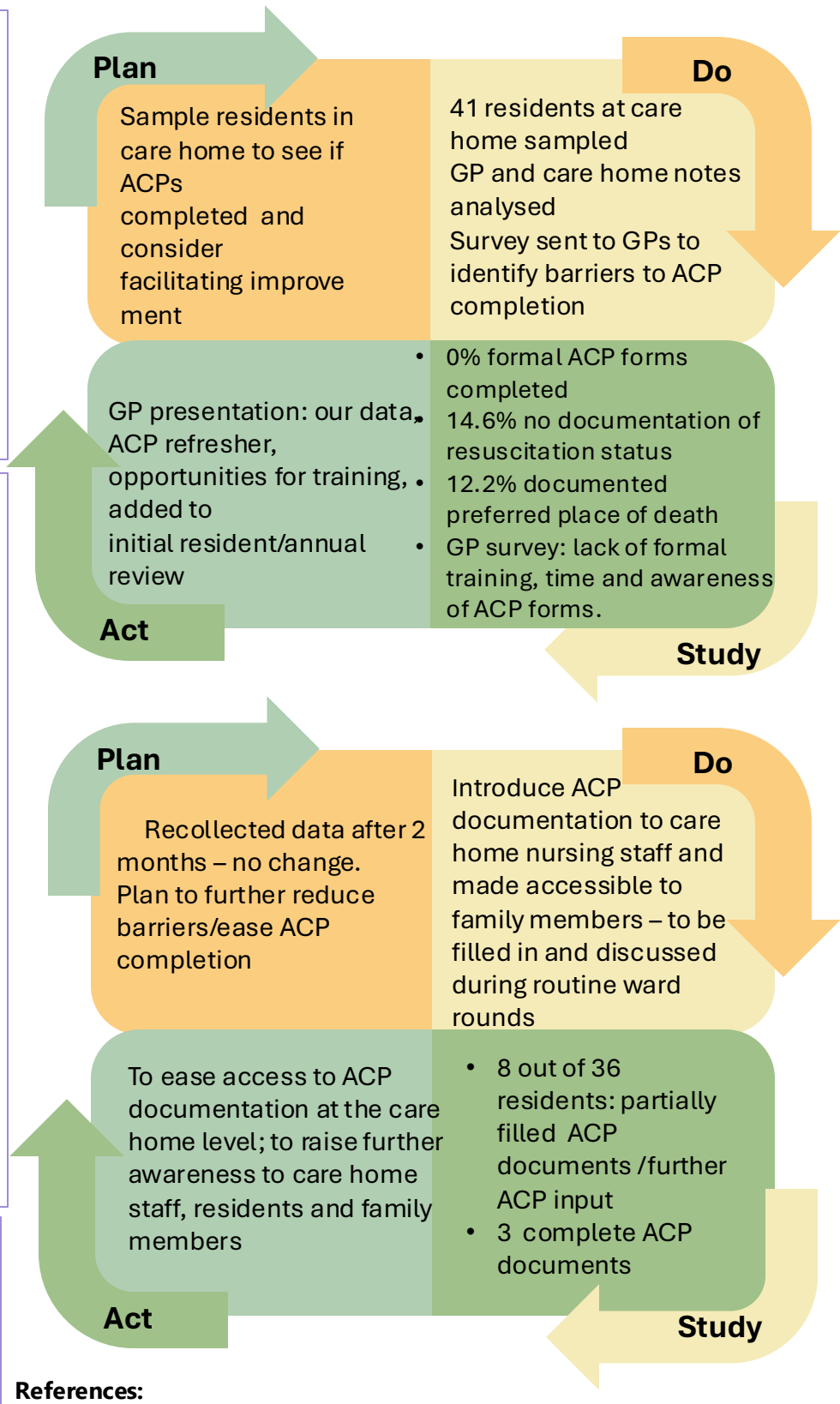
- Inconsistencies between care home and GP records
- Multiple instances of 'will discuss next time'
- Often ACP discussed only in acute deteriorations; early discussions undervalued
- An occasion where patient has been admitted despite ACP indicating 'not for hospital admission'

Conclusions

There is some evidence of ACP discussions taking place, but the official documentation is not used which could lead to lack of clarity of patient wishes. Whilst raising awareness of ACPs at the general practice was valuable, it was clear that addressing time constraints and workload was more effective in facilitating discussions and documentation. With an MDT approach of involving community care staff, family members and the residents themselves, there can be improvement in future care planning

Future steps

- Auditing at a secondary care level
- Bridging the gap between ACP decisions between primary and secondary care
- Public health initiative to raise awareness of the value of ACP's



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