Enhancing Junior Doctors' Competence in Advance Care Planning: A Focused Training Initiative

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Definitions:
Advance care planning (ACP) is a process that allows individuals to make decisions about their future healthcare, including end-of-life care, by discussing and documenting their preferences, values, and goals with healthcare providers and loved ones.
Emergency Health Care Plan (EHCP) is a documented plan that outlines specific medical actions and interventions to be taken in case of a medical emergency, tailored to the individual needs of a patient. This plan is created in consultation with healthcare providers, patients, and their families to ensure prompt and appropriate care during urgent situations.

Aims:
To understand the barriers that Resident doctors face surrounding creating EHCPs
To conduct a series of teaching session about EHCPs for Resident doctors of various training levels
To build the confidence of Resident doctors to hold conversations about EHCPs and document them appropriately.

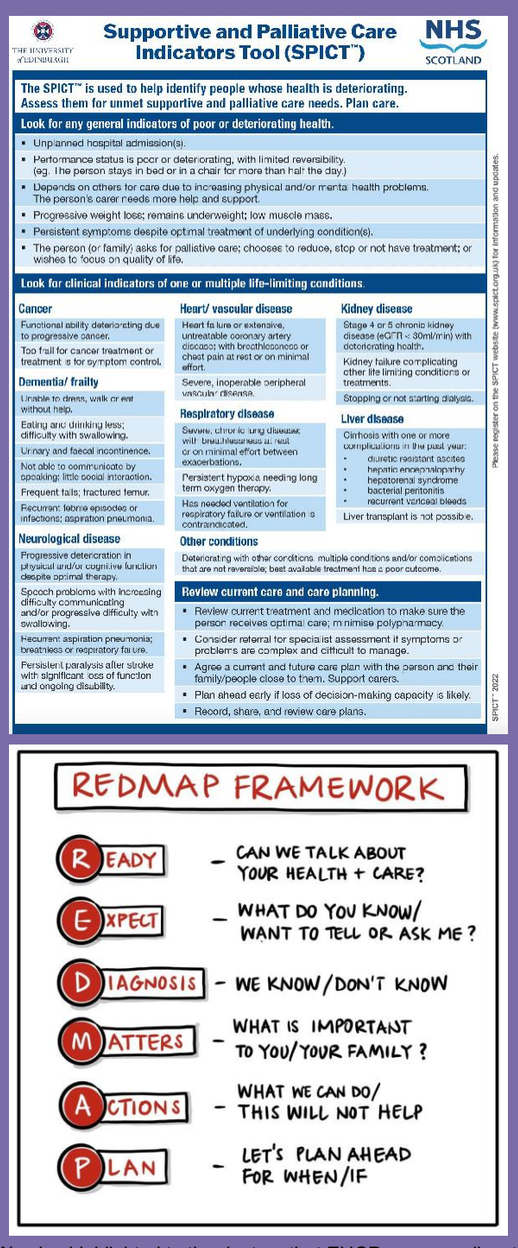
Background:
University Hospitals of Leicester (UHL) uses EHCP forms to document advance care plans for patients with whom these conversations are held with during their admission. These forms are broad and allow discussion around patient wishes regarding not only end of life care but also looking at reasons the individual would want to be admitted to hospital and specific treatment options including asking things like "what would you like to happen if you were to have a fall at home?".

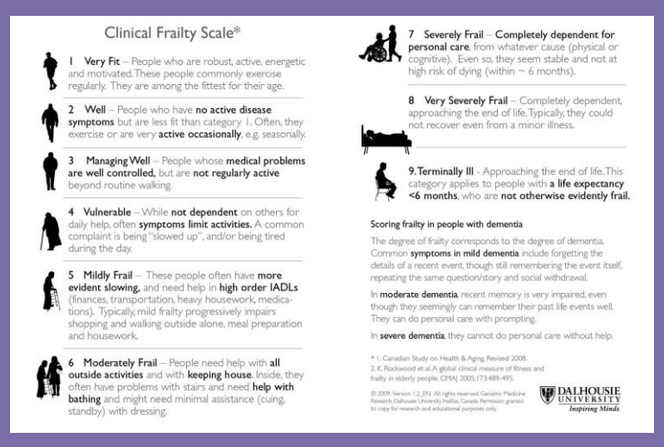
These forms are then able to be given to the patient and their family so they have a record, can be sent to the patient's General Practice to be attached to their community medical record and a copy is also placed in the patient's Hospital notes. This approach ensures patient centred care, however the number of these completed is fairly low, this project explores why this is the case.

We have conducted three cycles of this Quality Improvement Project (QIP):
The initial cycle (intervention round 1) taking place from January to August 2024, initially focused on educating select groups of resident doctors on EHCPs and analysing whether this impacted on the overall number of EHCPs completed.
The second cycle (intervention round 2) and third cycle took place afterwards, with expanded teaching and discussion with juniors regarding the barriers that they face surrounding EHCP conversations and documentation.
We collected data how many EHCPs has been documented among Frail Older patient (Age >65 years, Clinical frailty score more than 6)
The data showed that among patients admitted with a CFS greater than 7, an EHCP was completed in 0.4% of cases.

Methodology:
Firstly we pulled data from UHL records of the number of EHCPs completed between January and March 2024, identifying that 39 forms had been completed. From this a teaching session was then designed and delivered by Care of the Older Person Registrar Dr N Hashem. This session was then delivered to trust grade doctors who were asked to complete a questionnaire pre- and post- teaching session in relation to their confidence surrounding EHCPs. Following this data was then collected for how many EHCPs were completed from June to August 2024, identifying that 36 EHCPs had been completed, with a dramatic reduction in forms completed in August 2024 (n=3).
For the second cycle of the project, teaching sessions are being expanded to encompass a broader range of grades of resident doctors, and we are aiming to identify reasons for not completing the EHCPs.
The third cycle also showed similar number of EHCP (33) despite ongoing teaching programme.

Teaching sessions:
The teaching sessions were held in the optional teaching sessions for trust grade doctors which run out of hours.
The sessions taught what an EHCP is, why they are important, how to identify patients who may benefit from an EHCP and detailed an approach to take when having these conversations with a patient.





Images 1 and 2. SPICT and Clinical Frailty score. These are tools which have been created to help to identity patients who are either frail, or have deteriorating health. They aim to identify patients who may then benefit from discussions surrounding escalation plans and whether they would be suitable for support care and palliative care needs.

During our teaching sessions these tools were explained to resident doctor to improve understanding of the changes in an individual's overarching status that should highlight to you that we should be having conversations surrounding Advance Care Plans and escalation plans.

These scales aim to identify patients physical reserve approximately 2 weeks prior to their admission.

Image 3. REDMAP framework. This is a framework which has been developed to outline how to approach conversations with patients and their relatives about their desires around future care.

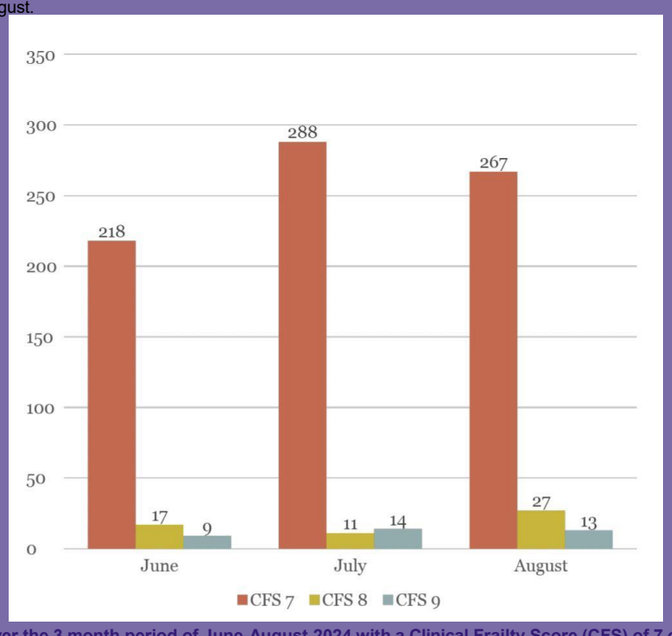
Our teaching sessions then drew upon the REDMAP framework to empower doctors with a tool for how to effectively conduct these conversations with patients about advance care plans.

We highlighted the importance of discussing the following domains with the patient and their next of kin:
- Infection
- Falls
- Strokes/TIA
- Bleeding
- Confusion
- Nutrition
- Head injury
- Breathlessness
- Chest Pain
- Loss of mobility

We also highlighted to the doctors that EHCPs are an adjunct to patient care and do not replace ReSPECT forms.
Finally we showed an example of an EHCP in the UHL format.

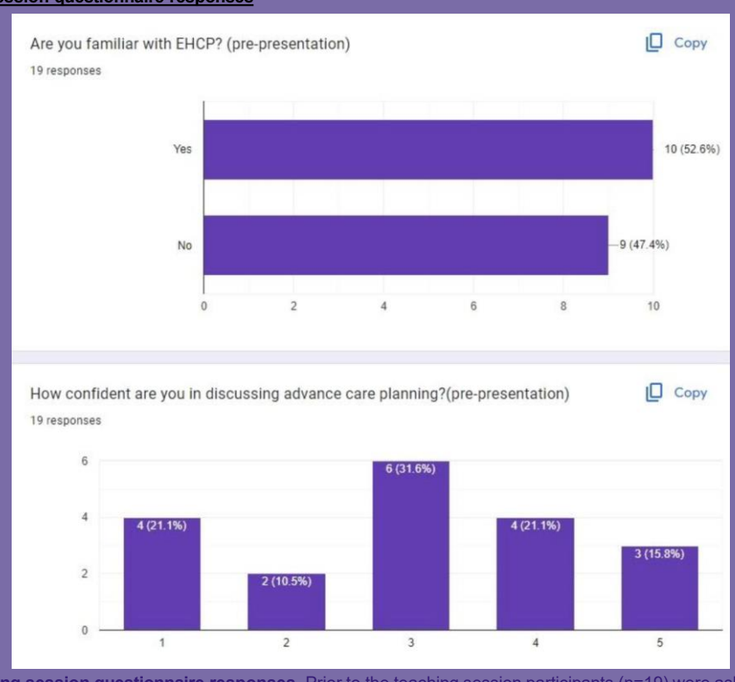
Admission numbers of patients to UHL eligible for EHCPs:

Graph 1 below shows the number of individuals admitted to UHL between June and August 2024 whom it may be beneficial to discuss EHCP and ACP with, split by their clinical frailty score (CFS) which is outlined in the box above. On discharge, in June 17 individuals had EHCPs with this number reducing to 16 in July and 3 in August.

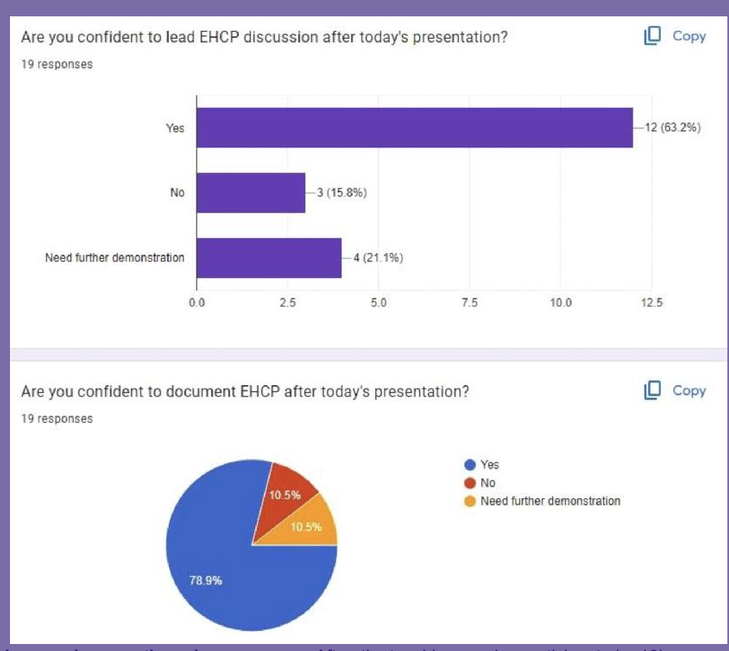


Graph 1. Admissions to UHL over the 3 month period of June-August 2024 with a Clinical Frailty Score (CFS) of 7 or higher. The individuals included in the graph above has been separated according to clinical frailty score, which each of the individuals above potentially benefiting from conversations around EHCP and ACP.

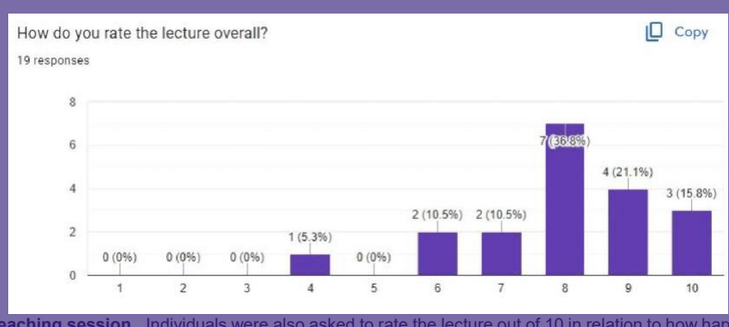
Pre- and Post- Teaching session questionnaire responses



Graphs 2 and 3. Pre- teaching session questionnaire responses. Prior to the teaching session participants (n=19) were asked the above two questions surrounding EHCPs.



Graphs 4 and 5. Post- teaching session questionnaire responses. After the teaching session participants (n=19) were asked the above two questions surrounding EHCPs.



Graph 6. Evaluation of the teaching session . Individuals were also asked to rate the lecture out of 10 in relation to how happy they were with the content and how it was delivered.

Results and Discussion
After completing the original round of teaching we found an overall improvement in the confidence that individuals had in both holding conversations surrounding EHCPs and documenting the forms. 63.2% of participants now felt they would be confident to conduct conversations surrounding EHCPs including conversations around the different areas of a care plan as outlined earlier, with 78.9% of individuals feeling confident to complete the EHCP form itself on the UHL system.
Interestingly more individuals felt that they would need further demonstration of how to hold these types of conversation (21.1% of participants) over documenting these discussions (10.5%). This leads us to believe that there are more barriers at play to completing EHCPs for patients than simply being unaware of where the form is and how to complete it.

We also asked individuals to rate the teaching session itself, if taking a overall ranking of an 8 or above to mean that the individual was satisfied with the teaching session, 73.7% were satisfied. This may also be impacted by the fact that some individuals felt that they would need further demonstration and that the teaching session in the original format does not meet their needs.

Additionally there was a striking drop in the number of EHCPs which were completed in August when compared to all the previous months, dropping from an average of 16 EHCPs to 3 EHCPS.
This timeframe matches with the change over in the resident doctors including the commencement in post for new F1 doctors.
It is reasonable to assume that this change in placement for doctors impacts upon their ability to complete EHCPs, whether this be due to working in new environments or time constraints from teaching new colleagues is unknown and needs further investigation.

Limitations in last 3 cycles:

Possible barriers include
-high doctor turnover,
-reduced staffing limiting time for discussions,
-the complex nature of ACPs—often requiring multiple sessions or being deferred to the patient's GP.
-Lack of knowledge about Advance care plan discussion and community facilities.

Ongoing 4th Cycle:
An audit will be conducted during the next teaching cycle to explore barriers and understand why increased confidence has not translated into improved completion rates
Identification of potential Target group on discharge summary so that they can be picked up in community for advance care planning discussions.
A survey will be conducted among consultants and middle grade doctors to explore the barriers to initiating advance care discussions in suitable patients.

References
1. https://www.spict.org.uk/the-spict/
2. https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf