Advance Care Planning (ACP) using PEACE and PACe models to help reduce inappropriate hospital admissions for older adults: A pilot study to evaluate health care professionals’ views of service delivery

Dr Gary Bellamy¹, Dr Jennifer Stock² & Professor Pat Schofield ²

¹ Clinical Research Network, North West London
² Faculty of Health, Social Care and Education, Anglia Ruskin University
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Disclaimer

The views expressed in this report are those of the authors and not necessarily shared by The Academic Health Sciences Network of Kent, Surrey and Sussex (nor do they represent their policies).

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Address for correspondence

Professor Pat Schofield
Deputy Dean for Research and Income Generation
Faculty of Health, Social Care and Education
Anglia Ruskin University
Bishop Hall Lane
Chelmsford
Essex, CM1 1SQ
E-mail: Patricia.Schofield@anglia.ac.uk
or Gary.Bellamy@nihr.ac.uk

This project was started at University of Greenwich, where ethical approval was obtained. Due to staff employment changes, the project was completed at Anglia Ruskin University.
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Report structure

Section one of this report provides an overview of reasons underpinning the philosophy of Advance Care Planning (ACP) as well as the development of the PEACE and PACe models of ACP respectively. The findings are reported in sections two and three of this report and section four provides some key recommendations as well as ideas for future research.
Executive Summary

This report has been compiled by researchers from the University of Greenwich to highlight the barriers, facilitators and similarities associated with the delivery and implementation of two different of models of Advance Care Planning (ACP) provided by two groups of health care professionals. The first is GP led model using a document called PACe (Proactive Anticipatory Care Plan) and the second is a nurse led model with community geriatrician oversight using a model called PEACE (Proactive Elderly Persons’ Advisory Care). The former document is a variation of the PEACE document. Funded by a small grant from the Academic Health Sciences Network of Kent, Surrey and Sussex in 2014 this report outlines the views of five GPs from practices in Guildford and Waverley Clinical Commissioning Group (Pilot Site One), three Sussex Community Trust care home admission avoidance matrons working in NHS Coastal West Sussex CCG and the experiences of managers and care givers from residential care homes providing care ‘on the ground’ where the PEACE model had been piloted (Pilot Site Two).

A combination of telephone interviews and face to face interviews were conducted with participants to elicit their views of both ACP documents to improve care giving at the end of life. The scope of this research did not include the views of older adults themselves - participants in this study whose care was supported by the use of either a PEACE or PACe plan were often too cognitively impaired. Further research regarding the use of ACP with older adults with a range of chronic health conditions such as heart failure, COPD, cancer and dementia as well as the views of family care givers is also warranted.

As this pilot study explored the use of two different models of ACP implemented by two different groups of health care professionals, the report has been set out to reflect those differences. As a result, findings from each have been set out separately. Notwithstanding these differences, during our analyses, we found a number of similarities across the two which together we anticipate would serve as recommendations for practice as well as ideas for future research. We have included excerpts taken from the interviews to illustrate some of the key themes identified in the findings section of the report.
1. Background and Introduction

Advance Care Planning (ACP) discussions are an important means of improving end of life care and enabling better planning and provision of care in line with the needs and preferences of patients, their carers and family members. ACP discussions are important conversations that can change practice, inform and empower individuals. ACP can be a process of discussion over time, need not be too over-medicalised or too formalised, and can be undertaken by anyone involved in the provision of palliative and end of life care, although is best undertaken by experienced staff following additional training (Thomas and Lobo, 2011).

The practice of ACP affirms the use of advance statements, in which people are able to clarify their wishes, needs and preferences for the kind of care they would like to receive. It can also include advance decisions or refusals of specific treatments including cardio-pulmonary resuscitation, and the appointment of a person to act as a proxy surrogate e.g. Lasting Power of Attorney. The process of ACP can be valuable in itself for all, but for many, it relates to the possible future development of incapacity i.e. clarifying wishes and preferences in anticipation of possible future decline. For older people living in care homes, this means ensuring that their choice for care at the end of life is respected. Staff that care for residents with dementia often have difficulty ascertaining their wishes and preferences especially for those with no family. Difficulties can arise when GPs are reluctant to make advanced decisions. According to Holman, Sawkins and Hockey (2011) staff are well aware of the unnecessary distress that can be caused by sending a person with dementia out of their environment into hospital and their own distress and powerlessness seeing residents with dementia transferred in the last 48 hours of life because of a lack of documentation relating to resuscitation status for example.

1.1 PEACE and PACe tools to inform end of life care

The PEACE plan (Proactive Elderly Persons Advisory Care plan-see appendix A) is a document to help guide health care professionals in delivering the best care to frail, older people with life-limiting illnesses (such as those with Parkinson’s’, advanced dementia and cancer) who are anticipated to be in the last year of their life and reside in a care home. It records discussions between the older person and/or their representatives and the geriatric team about what that best care might look like in the future when the older person’s health starts to decline further. Discussions may cover topics such as feeding, infections and whether coming back to hospital might be a beneficial or detrimental event for the older person.
The PEACE document was first developed at Kings College Hospital, London. Research and audits showed that many older adults, especially those with advanced dementia, were being admitted to hospital in the last few days of life and dying in hospital in distress rather than in the comfort of their care homes. By discussing with the older person and/or their representative where they would like to be cared for at the very end of life, the PEACE plan has helped to increase the number of people who spend their last days in the familiarity of their care home and reduce inappropriate hospital admissions (Hayes et al, 2011; Kalsi et al, 2011). A version of PEACE known as the Proactive Anticipatory Care Plan (PACe) tool is a document has been adapted for use across primary care, community and acute care settings, from the original PEACE tool to inform care at the end of life (see appendix B).

1.2 Research aim
To identify the barriers, facilitators and similarities associated with the delivery and implementation of two different of models of Advance Care Planning (ACP) provided by two groups of health care professionals.

1.2.1 Objectives
- Explore the views of GPs associated with the development and delivery of the PACe (Proactive Anticipatory Care Plan) tool to inform end of life care for older adults.
- Explore the views of nursing and residential aged care staff associated with the development and delivery of a model of care with community geriatrician oversight using PEACE (Proactive Elderly Persons’ Advisory CarE), to inform end of life care.
- Explore the similarities and differences associated with both models.
- Highlight the key findings to study partners and identify how the findings from this pilot can be used to inform a larger study that will benefit future patients.

2. Methodology
Participants who took part in the pilot study were employed by two NHS organisations and two private residential aged care facilities located in the South East of England. GPs with experience of using the PACe tool were employed by NHS Guildford & Waverley CCG (a GP led model) and Sussex Community Trust care home admission avoidance matrons working in NHS Coastal West Sussex CCG (a nurse led model with community consultant geriatrician oversight) provided the research team with their experiences of the PEACE tool. Care staff in two private residential homes provided the
research team with their views of using the PEACE tool ‘on the ground’. Ethical approval to conduct
the study was obtained from the University of Greenwich Research Ethics Committee (reference
FREC/EH/14-003 BELLAMY). Once approval was granted, participants were invited to take part in
either a short face to face or telephone interview with a trained university researcher. Prior to
interview, participants were provided with an information sheet (appendix C) and asked to sign a
consent form (appendix D) and complete a short demographic questionnaire.

Telephone interviews were conducted with five GPs to explore their view of the PACe tool. Three
admission avoidance matrons took part in face to face interviews and four care staff employed by
two residential care homes took part in individual telephone interviews. A total of nine telephone
interviews and two face to face interviews (one joint and one individual) were held with twelve
participants.

2.1 Data analysis and reporting of interview data

Face to face and telephone interviews were digitally recorded and transcribed verbatim. Analyses
were carried out according to the tenets of theoretical thematic analysis (Braun and Clark, 2006).
The method has been widely used across the social, behavioural and more applied (clinical, health,
education) sciences. In line with Braun and Clark (Ibid) a six-phase approach was adopted which
involved the following:

1. **Familiarisation with the data:** This phase involved reading and re-reading the interview
   transcripts, to become immersed and intimately familiar with their content.

2. **Coding:** This phase involves generating succinct labels that identified important features of the
data.

3. **Searching for themes:** This phase involved examining the codes and collated data to identify
   significant broader patterns of meaning (potential themes).

4. **Reviewing themes:** This involved checking the candidate themes against the dataset, to
determine that they told a convincing story of the data, and one that answered the research aims.
   In this phase, themes are typically refined, which sometimes involves them being split, combined,
or discarded.

5. **Defining and naming themes:** This phase involved developing a detailed analysis of each theme,
working out the scope and focus of each theme, determining the ‘story’ of each. It also involved
deciding on an informative name for each theme.

6. **Writing up:** This final phase involved weaving together the analytic narrative and data extracts,
and contextualising the analysis in relation to existing literature.
3. Findings

3.1 The PEACE Tool

Six participants took part in face to face and telephone interviews to discuss their experiences of their involvement in the pilot of the PEACE tool. Three admission avoidance matrons took part in face to face interviews with a researcher and four care staff working in residential care homes took part in a telephone interview. During close and careful reading of the interview transcripts, there was considerable trepidation expressed by the nursing staff in relation to leading the pilot albeit with community geriatrician oversight. Based on our analyses, a total of five themes emerged from the data. These include: PEACE as a tool to inform future care and treatment preferences; the importance of existing relationships; reflective practice; medical support as a fundamental PEACE facilitator and difficulties associated with PEACE in its current format. Whilst there is significant overlap with the themes identified with both tools, together, these will to be highlighted as a springboard to making the recommendations for practice and ideas for future research in the final section of this report.

3.1.1 PEACE as a tool to inform future care and treatment preferences

Participants highlighted the importance of having a document that they could easily refer to that enabled them to provide care that was in line with their wishes. In the case of care home staff, this provided them with the confidence to advocate on behalf of care home residents behalf - particularly night staff that lacked the support that day staff could readily draw upon - as the following interview excerpts highlight:

‘They (staff) feel really thrilled with it (PEACE tool). Especially the night staff. That’s why I brought that up because it was them that said it was nice that they’d got a plan as to what’s going to happen. We’ve always got lots of people that we can call in the day but at night and at the weekend you’re limited so they seem really pleased with it.’ Care Home Manager. Home A

‘Well, my own view is that it’s (PEACE tool) really helpful for us; we can see most of it that we can do for the resident in case we have some problems and then we can go to the PEACE plan and we will know their history and what we can do for them.’ Care Worker. Home A
‘It (PEACE tool) helps us really, how to manage any medical symptoms that we notice with the resident so if they’re having some medical problems, we will know what to do.’ Care Worker. Home A

The same manager in care home A also felt that the tool, despite sometimes being time consuming to start with, in the long run would be nothing but advantageous to the resident in terms of focused end of life care. As they go on to explain:

‘Although we haven’t had an incident where we’ve used it (PEACE tool) in its entirety I do feel that it’s going to be nothing but a benefit to us as a home. We have a lot of district nurses coming in, GPs and it’s nice to have that one document that everyone’s aware of and we have the plan rather than different people changing things...and us as carers not knowing what we should be doing and what’s right and it also gives us that knowledge to be able to, if an out of hours GP wanted to change something, to have something that we can show them and say well no, this is what the plan was...’ Care Home Manager. Home A

These views are corroborated in a joint interview with two admission avoidance matrons as a way to inform the provision of good end of life care. As one of them goes on to argue in the case where capacity of lacking in the patient:

‘I think it’s (PEACE) a really good tool to just kind of expand the end of life discussions and actually get some practical construct to what people believe will happen at the end of their life and how we can facilitate what their wishes are and also with a focus on admission avoidance, the two generally go hand in hand and I think it’s been a really useful way of discussing that with patients’ relatives.’ Admission Avoidance Matron

3.1.2 The importance of existing relationships

Existing relationships with residents, family members and colleagues alike were considered fundamental to the success of PEACE. As one participant explains:

‘I’m quite lucky in that (care home manager) will do quite a lot of the background work for me so she has forums with her relatives so she introduced at a forum where all of the relatives go and they all wanted all of their relatives to be on it (PEACE). Admission Avoidance Matron
‘I make sure I know my patient because I don’t think that you can go in there with not knowing them that well. I think you need to have done those initial assessments and got to know them, you know, what makes them tick, what they like, what they like to be called, so that you can engage with the relative much better, so that they know he or she is not just a number, or you’re just doing this to everybody. It’s that personable bit that you bring to it and I felt that that was really important to do that.’ Admission Avoidance Matron

In addition to the importance of good interpersonal relationships, clinical experience was also considered to be important to perform well. As the following participant argues:

‘But I think you need to be senior and I think you need to have really good, I’m not blowing our trumpets but you need to be able to communicate with people really well but you also already have to have a relationship with these people for it to work. They have to see what you do, you do well, you sort them out. You fix things for them so that if they’re going to embark on this kind of thing with you, to take it seriously they’ve got to know that you’ve followed it through with them.’ Admission Avoidance Matron

3.1.3 Reflective practice

Reflecting upon what the PEACE tool has given to residential care home staff and residents alike, participants felt that it had strengthened their ability to advocate for residents with end of life care needs to afford them a good death in line with their wishes:

‘I think it (PEACE) just reinforces what we are already doing. It’s very difficult because I don’t work on the floor as much as the others do but from my point of view I just feel it reinforces what we do and it also gives the senior carers peace of mind. They’ve got a document that they can refer back to as have I in times that I’ve thought ‘is there a PEACE plan for this’ and I’ve gone through it. I think it makes us think outside of the box more. I do think that rather than the knee jerk reaction now, I mean we’ve got one lady who’s not on the PEACE plan but it makes us think about PEACE...’ Care Home Manager. Home A

Study participants also highlighted the idea that the tool had enabled them to reflect on discussions and consider ways that potentially inappropriate hospital admissions could be avoided in the future and to think through issues that might arise in the future. As the following two participants assert:

‘I think some of it (PEACE) was helpful because it made us sit down and have discussions with residents and their families... the good thing about it (PEACE) was it was highlighting areas
where you might have to send them back to hospital and areas where you could manage them within the home.’ Care Home Manager. Home B

‘I think it makes me have a much more, a better understanding when I’m talking to other patients about end of life, and I’m talking about things like getting DNARs in place, I’m thinking more deeply about the implications and thinking well, if x, y and z happens what would you like? It’s not just a DNAR discussion anymore. It’s that advance planning in greater depth, more rounded probably.’ Admission Avoidance Matron

In addition, they also claimed that taking part in the pilot had given them the confidence, skills and a self a new sense of self believe that was previously lacking from their clinical practice. As the following participant explains:

‘It’s (PEACE) given me confidence and I think now I do think more. I think before I did it I gave a lip service to the, because we’ve got advance care plans, I don’t think you’ll have seen them. Maybe I can send you one. And we’d say to the home, have you thought about the advance care plan, have you done it and I don’t think I went in to enough depth to say right ok, let’s review this because I didn’t feel maybe I had enough skills to do it and I was asking another person to do it and really I think I can go now do you need some help and support with it, why don’t we sit down together, why don’t we talk to the relative so I think it’s made my practice much better.’
Admission Avoidance Matron

3.1.4 Medical support as a fundamental PEACE facilitator

‘I think it is a good idea and I think it works if everybody’s working together with it and has a clear understanding of what it is all about... the problem with a lot of these things is you start to do one thing with one person and they leave, unfortunately. It’s just everywhere, isn’t it? Someone else comes in who has a totally different idea or a totally different view on something and it means you’re kind of back to the beginning again, you know.’ Care Home Manager. Home B

The preceding interview excerpt highlights the importance of a consistent approach to a particular initiative. During the course of the pilot, participants expressed difficulties associated with medical staff in particular not backing the initiative. This backing was considered fundament to the success of the pilot. Stories emerged where medical backing gave authority to the pilot and in instances where this failed to happen it undermined the confidence of those involved. As the following interview excerpt demonstrates:
‘The GPs were sort of on board but then they didn’t give me any back up and then one of them left and nobody at the surgery would put anybody forward. It was just, yeah, yeah, yeah but nobody would say I will work with it. I mean it’s not as if I’m going to ask them to do anything. I just want them to see the plan and be aware of it. That was a little bit of a glitch really. They paid lip service to it which was a bit upsetting really and then as the ones left that was really involved in it, and then when I’ve emailed the practice manager and (care home manager) emailed the practice manager and it’s been a case of ‘yeah, yeah, we’ll all help’. No. I want one of you, I can’t put all of you on there I want one of you to work with me and there’s been nothing, its gone cold.’ Admission Avoidance Matron

Participants claimed that having the weight of the medics behind the pilot to sign off the PEACE plans gave it that extra credibility. As the following two interview excerpts demonstrate:

‘...so having their signatures behind that, having in-depth discussions with them adds a lot of weight...’ Admission Avoidance Matron

‘I think the credence lent to it (PEACE) by having game players if you like, like GPs and consultants, that lends a lot of credence to what is being discussed and it supports us which again gives it more credence to the kinds if discussions you having and it makes you a braver about having those discussions.’ Admission Avoidance Matron

3.1.5 Difficulties associated with PEACE

Participants highlighted the problems that arose with the PEACE in the initial stages when attempting to co-ordinate a meeting between health care professionals and family members to talk about a subject that was considered sensitive. As the following participant explains:

‘It’s been really difficult to try to set up because you’re having to liaise at times when the family is available as well as myself so it has at times been a bit tricky and also we’ve had some conversations that have been a little bit tricky as well because you’re talking about end of life, you know, what we want, what’s going to be best and some people don’t like talking about these subjects and were also doing on how frail these residents are so it looks like whoever is going to deteriorate faster that’s who we put on the PEACE plan first. Like a priority order.’ Care Home Manager. Home A
Additional difficulties that were highlighted related to the time consuming nature of having to collect numerous signatures to demonstrate that everyone involved in the plan was in full agreement with what had been documented:

‘One of the difficult things I found was all the running and toing and froing, a lot of homes were very rapid, react as well as planned interventions. So it was very time consuming. You’d go, the families, the home, educating the home, getting all that on board, the patient themselves, then going to the GP who maybe wants something doing maybe slightly differently and then you went to the consultant so it’s a lot of man in the middle kind of thing.’ Admission Avoidance Matron

In addition, there were problems experienced when the final paper copy of the PEACE plan needed to be signed and it was time consuming obtaining those signatures. As another care home manager argues:

‘...the difficulty was I understood they had to be signed by a hospital consultant and all that and this is where it got quite difficult because it ended up that we had to send them all back to the hospital to be verified and signed and that seemed to take a long time.’ Care Home Manager. Home B

The burdens associated with a paper-based system were manifest in the accounts of those participants involved in the PEACE and PACe pilots respectively and expressed a preference for some form of electronic system to record and share information:

‘Not to change the plan but I would have liked the fact that, it was the paperwork bit that got me...so I would meet with the relatives, I then had to then go back, I had to bring it up on my computer back here, I then had to start writing it...if we’d had a laptop and I think this is something that we brought up, we could have done part of it as we went... It just felt laborious. You just think there’s got to be a way of speeding this up... but then part of me felt that would be rude but I’m not sure...or would it be better with a tablet? I don’t know but it just felt that part of why I was so slow was I could be writing it as I went and I did a lot of extra hours myself to make sure that I could say to the family, I will have it to you, and I kept thinking how much more can I keep doing...that we could just download it to streamline the process. It is the daunting factor that you’ve got to put the demographics in and it just felt like that and if there was just maybe a way to populate the patients details from system one,'
or whatever, because it was just a lot of me physically just putting in date of birth, all that kind of thing and you’re thinking...really! (laughs)’. Admission Avoidance Matron

‘I think I’ve struggled a bit in terms of getting the information made electronic. That’s the bit that been really frustrating. That’s the bit that took three weeks to get five, six documents scanned onto a computer and uploaded onto IBIS and still I don’t think that they’ve been uploaded so it’s that technology aspect that which has been really slow.’ Admission Avoidance Matron

Participants claimed that some of the difficulties that they experienced to make end of life care provision more seamless could be overcome if the tool could be shared electronically between the various care providers:

‘It (PEACE) needs to be electronic to make it a bit more seamless. That would help us in terms of, you could ping it securely to GPs, and it would help us, and consultants by secure email.’ Admission Avoidance Matron

‘Electronic, electronic, electronic. Let’s make it electronic basically!’ Admission Avoidance Matron
### 3.2 Nurse led model case study

Case study, with some details changed to prevent identification of the patient and family, below:

<table>
<thead>
<tr>
<th>Patient Background:</th>
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<tbody>
<tr>
<td>Mrs P was a 91 year old lady who lived in a nursing home in Bognor Regis. She had had a stroke in 2004, previous fractured pelvis, fractured hip, had a PEG tube placed in 2014 for enteral feeding. She had made wishes evident that she did not want future admission to hospital, she had capacity and her daughters were aware and in agreement with this decision. There was an advanced care plan in place and a DNACPR in place. PEACE plan was completed. This was a decision reached and discussed with a Consultant (DOME), GP and daughters that Mrs P should ideally not be admitted / conveyed to hospital, particularly if she were to suffer a further stroke or if PEG tube needed re-inserting, chest infection /pneumonia. However, in the event of a likely fracture, admission was appropriate. A review of Mrs P’s PEACE plan was undertaken in May 2015 and refined slightly to allow specific treatment if PEG became dislodged or blocked i.e. Sub-cut fluids short term if dehydration signs were troubling for Mrs P. Also a review conversation with one of the daughters to ensure still in agreement with current plan.</td>
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<th>Patient Journey:</th>
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<td>Mrs P had remained stable in the interim, with minimal changes to her health status. 3 months after PEACE plan, Mrs P became very unwell suddenly after 1 day of liquid antibiotics for a chest infection, and her daughter and OOH were contacted, OOH sent GP, who reviewed Mrs P and initially was keen to admit as likely chest infection. However the nurse explained the whole idea and concept behind the written and agreed PEACE plan (new to him) and phoned the daughter to confirm in agreement and Mrs P was NOT conveyed and remained in her home and died peacefully at home with anticipatory medications in the early morning.</td>
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<tr>
<th>Additional Interventions:</th>
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<tr>
<td>There were none</td>
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<th>Improved Outcomes:</th>
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<tr>
<td>Did the interventions improve care of the patient and the outcome?</td>
</tr>
<tr>
<td>Yes – following completion of PEACE plan the home staff were braver in having conversations pertaining to end of life. Also heightened awareness of those needing end of life plans to be in place as deterioration signs heightened. In this case Mrs P was not conveyed and the staff and family were happy with the final outcome; however staff felt they had to act as strong advocates to reassure the OOH team that this lady did not want admission and the plan was in place to prevent unwanted admission.</td>
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<th>Learning:</th>
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<tr>
<td>What could have been implemented to improve the patient experience?</td>
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<tr>
<td>OOH /One call better awareness of PEACE plan PILOT site and the implications of a PEACE plan.</td>
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3.3 The PACe Tool

Five GPs from different health care centres in the South East of England took part in the study. Their experiences of using the tool were wide ranging and participants spoke of having adapted the tool to suit their own needs. One GP who took part in the pilot had not used the tool per se but had taken the decision to use their own ‘in house’ documentation. Five main themes emerged from the data. These include: the importance of existing relationships; creates and focuses conversation; a ‘go to’ document; reflective practice and difficulties associated with the PACe tool.

3.3.1 The importance of existing relationships

Participants highlighted the importance of having prior knowledge of the patient and their family in order to advocate on their behalf and complete the PACe document. This aspect was of particular significance if that individual was cognitively impaired. As the following participant highlights:

‘I think the fact that our patients have known us for many, many years. I know a lot of our patients have very complex medical problems and are looked after by the hospital and probably feel that they’ve got a closer relationship with that hospital except I think that’s very much the minority. And I mean it’s just nice for us because we see patients at home, we know their home set up, we know their family and that just makes having those conversations that bit easier as well.’ GP4

Not wanting to pull rank, the majority of GPs who took part in the study felt that the interpersonal relationship was fundamental to successful end of life care discussions and every situation had to be taken on its merit. As they go on to explain:

‘I think it is the clinician who has that relationship with the patient or their family in the case of somebody who doesn’t have capacity and somebody who they trust. I think it is the relationship that is important and I think I would say that the care staff would sort of have a better relationship with the family and see them, I mean I never see them, I’m just a GP that happens to phone them. I think it is more about the trust and relationship with that bit. I think sometimes it is, I don’t know, it’s difficult to explain to erm, yes I guess it is more about the relationship...’ GP 1

‘I think it’s whoever’s closest and knows the most about that patient.’ GP2
In addition to the importance of prior knowledge of the patient, participants with experience of using the tool highlighted the importance of particular characteristics to enable those conversations to take place. As another participant explains:

‘...being able to say things in the right way, not being abrasive by saying ’so how do you want to die or where do you want to die and clearly haven’t thought about it and clearly that’s not the best approach. I think a gentle way of leading the discussion towards...rather than just picking on the end of life, because there are all sorts of other avenues to discuss. And actually I think most people do respond very well to it so. I think its helpful doing it, know a patient, I think as the GP we know our patient and I think the nurse will know the patient well so they’ll already be in a position of trust. If you’d got somebody who didn’t know the person, that might not work and it’s not the most ideal approach.’ GP3

3.3.2 Creates and focuses conversation

Participants pointed to the idea that having these documents enabled them to have conversations, often over a period of time, to enable individuals and their family members where appropriate to come to a decision about their future care and treatment preferences. The GPs highlighted that they had experienced very little resistance to having such conversations. Instead, they felt that they had enabled individuals and their family to clarify their own thoughts and feelings over a period of time:

‘...none of us want to force any sort of immediate decisions on patients. If we do it (talk) nice and early we’ve got time to play with, to be able to give them time to think and come back to us, its, it doesn’t have to be immediate which is what’s quite nice about it.’ GP4

‘Well...patients are pretty open to it (end of life care discussions). I mean a lot of patients that I’ve come across, say it very much depends on the individual situation and they’d need to make their decision at the time as to what they’d do and don’t want doing with regards to their health. I’ve found with some of our patients we’re a little bit unclear on it which, it’s really helpful to get the next of kin involved in that conversation and you know, I think it just creates conversation within the family and then people get back to us and say, ‘we’ve had a think and these are what our thoughts are’ so that’s been quite useful.’ GP4

‘When I did it with those community based patients they were generally were appreciative of the structured way and the approach to the questions, it opened up a lot of questions for themselves that they hadn’t considered.’ GP1
3.3.3 A ‘go to’ document

Despite the majority of participants asserting the time consuming nature of completing the ACP documentation, done well, they felt that they saved time in the long run and served as a useful ‘go to’ document:

‘I think it’s (PACe) an absolutely brilliant idea. I think a lot of our frail and elderly patients do end up ringing out of hours and obviously they’re quite complex patients and I think having all of the medical information there I think is really important. The other that we’ve found very useful is having all of the next of kin details, having information about power of attorney; you know having that all on record that’s really helped us as well. So that’s all of the main things from our point of view.’ GP 4

Commenting on the PACe tool itself, in comparison to other ACP documentation, it prevents clinicians from skipping areas they might otherwise feel uncomfortable with thereby making it a more holistic document. As the following participant highlights:

‘...it (PACe) takes you slightly more slavishly if you like through the various areas. You know, it’s more difficult to brush over some of the areas. You have to sort of fill in a box, well you don’t have to fill in a box but erm but it’s just more difficult to avoid...’ GP 5

3.3.4 Reflective practice

Participants highlighted that rather than changing their practice, the PACe tool had enabled them to reflect on their own practice, the conversations they had with patients in the last year of their life and to take particular issues that they had learnt forward to benefit future patients:

‘...it’s definitely made me think more about you know, especially knowing sort of more about the next of kin and power of attorney and sort of thinking about that side of things as people, as sort of our elderly patients sort of just, I suppose as they deteriorate.’ GP 4

‘It has made me think a little bit more, as a GP you tend to think a little bit deeper. It’s made me think a little bit more about the frailty issue, you know, on paper they look alright but looking at them....maybe it’s made me look at things a bit more laterally.’ GP 3

‘Yeah. I think it has. It makes my care planning more focussed’. GP 5
In additional participants claimed that it enabled them to think about the whole process in greater detail and find out about a patient’s goals and aspirations. As another GP in the pilot study argues:

‘...it’s finding out more about the patients goals and stuff and whether they want...and it make you start to think about how can I proactively look after this patient to make sure they’re meeting their goals and not fall over on the way to doing that you know. So it tends to make you think...’ GP2

3.3.5 Difficulties associated with the tool

Overall, participants experiences of the PACe tool were positive. However, in line with those completing the PEACE documentation, their layout, often lengthy and paper-based nature combined with time pressures faced by clinical staff often meant that their translation into clinical practice was delayed. This was considered to be a limitation, particularly working with a group of individuals with a life limiting illness. Anticipating particular scenarios was also difficult as the following participant highlights:

‘...it’s very difficult to specify scenarios because you could go on for pages and pages and pages of different scenarios that could crop up...so I think it is just a matter of reviewing it regularly and as their health deteriorates you can think of, sort of new scenarios that might crop up that they may or may not want treating but erm...I completely understand why it’s so in-depth but especially with the time constraints in general practice anyway. I think my colleagues have found it quite a challenge to do.’ GP4

‘We can all look at the forms and add bits...we have an IT person here in the surgery and she’s very keen and so she can re-arrange the layout a little bit so that when we upload it, it’ll be easier to go through it.’ GP3

The same participant argues that the document does not flow as best as it could and needs to be refined in light of their experiences of using it in practice. As they go on to explain:

‘I know my IT person would love to discuss that with you and I’m sure if you’d got more time she would do. I know she rearranged, the second page should be the first page would be my first thing because it contains some of the explanation about how to do things. That’s the main thing I would find and also when it comes down to doing the DNAR form, it doesn’t say that, it says, I don’t know what the exact expression is and I look at it every time and I think ‘what does that mean?’ is the answer ‘yes’ that they’ve got one or the answer’s ‘yes’ they
don’t want one. It’s not very clear so you maybe need to change that to make it clear. I think those are the two things that immediately pop up.’ GP 3

Similar issues were expressed by another participant but this time, their concerns are related to the fact that the document was to be shared with patients and their relatives but it considered too clinically focused. As they assert:

‘I think the format we have is very clunky and not particularly user friendly, it’s a document and a history that’s supposed to be shared with relatives and I haven’t had any feedback. I think if I was given it as we use it, I think I would find it a very dry thing...I suppose for care home staff its slightly processy going through it. I think the clinical discussion about what to do is helpful for some, it’s difficult it, the sort of processy thing... I think it’s very time consuming. I think it’s just doesn’t flow in a consultation type mode. I think care staff, nursing staff are probably more, their training is probably more geared to protocol and just working through forms.’ GP 1

The same participant goes on to highlight the practical changes they would make to the document to make it better:

‘I would totally reverse it. I would put key headlines, clinical information, what you must do, our document, you have the diagnosis, because we don’t have the technology and the computer merging so it doesn’t fit that well. So the diagnosis isn’t that prominent, the reasons for having the document aren’t prominent...’ GP 1

She claims that it struggles to be all things to all people but the very crux of their argument relates to its paper based format which in practice, is slow to put into practice and share with all those agencies involved in the care of older adults with end of life care needs:

‘I mean we’ve got it set up as a template but I now actually print off a blank one, write it, give it to a secretary to type up and just, you kind of lose the plot because then its typed up, it has to be checked, it has to be signed, it has to be signed by everybody and then the final, final agreed copy is almost lost in this chain, you know, where does that live, should it live with the patient, you need to have a copy in the GP records, you need a copy in the care home records and then maybe something goes wrong and they go into hospital and it gets lost. I know there’s no electronic solution for sharing those notes on the horizon. So they need to be accessible, they need to be short... do you share it? How do you remember who’s
got the original? Did it go to the ambulance or didn’t it? Did it go to the hospital or didn’t it?
I’ve just got one, a beautiful PACE document from a resident and I’ve looked at it and I’ve thought well that’s totally out of date. So yes it’s keeping them live and updated and sharing them with everybody who needs to know.’ GP 1

Another participant highlights that having an electronic version that is password protected would help to overcome these difficulties to enable the correct version to be shared at the touch of a button as the following narrative highlights:

‘Certainly an electronic version would stop a lot of that running around with signing and stuff...where anyone can plug into with a password and update it for that patient that might be a handy thing.’ GP 2

Commenting on the look and overall feel of the PACe plan, another participant echoes previous concerns about its inability to be ‘all things to all people’:

‘...when you look at it now, it’s (PACE plan) horrible. I think as a patient if I received that a) I wouldn’t read it and b) I wouldn’t understand it. Erm, how it looks I think is really important if you want to get your patients engaging particularly the ones who have got still got capacity and their families as well so at the moment this looks like a really official document with 1.1, 1.2; there’s lots of blurb amongst the information that useful...so the doctor has to fill it in but it’s like well no, if you’re the patient you want the overall, this is my plan do you know what I mean rather than having all the instructions on how to fill it in...So I think if it did look nicer that would be good to look at...’ GP 2
3.4 GP led model case study

Case study, with some details changed to prevent identification of the patient and family, below:

**Patient Background:**

Mary, a 90 year old lady, with profound orthostatic hypotension and dementia, living in a nursing home. She was well known to the cardiology teams and had reached the ceiling of management for her hypotension. Over the past years, she had been in and out of hospital multiple times following a drop in BP/collapse, and frequently discharged home from A & E with nil new cause identified. This was very distressing for the patient.

PACe was completed. Decision with GP and daughter that Mary should ideally not be admitted to hospital, particularly if she were to suffer from low BP/collapse. However, in the event of a likely fracture, admission was appropriate.

**Patient Journey:**

A month after PACe completed, Mary was appropriately admitted to hospital with #NOF. This was treated surgically relatively quickly and she had a rapid discharge back to the care home.

Over the next few months, she seemed to deteriorate, her BP was very low and oral intake was reduced as a result of her dementia. The Macmillan team became involved and reviewed Mary from a palliative care point of view. Non-essential medications were stopped. She slowly deteriorated, and passed away peacefully at the nursing home.

**Additional Interventions:**

Macmillan provided support and guidance to home staff about patient’s condition, and how to manage short periods of unresponsiveness.

**Improved Outcomes:**

Did the interventions improve care of the patient and the outcome?

Yes – following completion of PACe, the home staff were better able to manage periods of unresponsiveness, and this prevented them from automatically calling 111/999. As a result, the patient and her daughter were much more satisfied with overall care.

**Learning:**

What could have been implemented to improve the patient experience?

Nil – the care plan once implemented worked very well in this case.
4. Summary Findings and Recommendations

4.1 Summary of findings

The findings obtained from participants the two case studies contained within this report would suggest that the PEACE and PACe documents have the potential to improve care at the end of life by documenting the future care and treatment preferences of older adults with a life limiting illness by obtaining information from a range of sources- older adults themselves or in the case those who are cognitively impaired, the views of relatives, carers and health care staff using a ‘best interests’ approach.

4.2 Information Technology and ACP opportunities

Both the PEACE and PACe tools are, in themselves, evidence enough to highlight the progress made to develop resources for ACP. Based on the findings from this study, these tools have demonstrated progress, but there is still a clear need to improve ACP delivery systems. Health care providers continue to indicate that patient volume, increasing patient complexity, the need to share information with multiple providers and an increasing paperwork burden has adversely affected quality ACP delivery. An increasing and ubiquitous use of health information technology, such as electronic health records and electronic health record-tethered patient portals, affords opportunities to streamline communication methods between various providers and their patients to help provide seamless end of life care. The opportunity exists to undertake an ACP randomised control trial using both documents with one arm supported by IT where care providers can share information electronically and the second arm that continues to use a paper based PEACE and PACe system of ACP. An 18 month study involving a number of residential care homes to identify potentially inappropriate hospital admissions in both arms should be undertaken and a subsequent economic analysis as well as a retrospective case note review to determine whether documented care pathways were followed and family carers (as a proxy measure) were satisfied with the care received.

4.3 Documentation layout

Participants indicated that the paper-based PEACE and PACe documents were awkward, counter-intuitive to complete in a timely manner. The documentation needs to be refined in light of the experiences of clinicians using it on the ground in terms of its user friendliness. Based on the feedback obtained from participants in this trial, further refinement is required by those individuals
using them in their everyday practice and the documents should be refined in light of the feedback obtained.

4.4 Future PEACE/PACe initiatives

Both trusts and residential care homes involved in this pilot should be encouraged to work together to share examples of good practice and, based on the relationships that they have forged be encouraged to take part in more research with the aim of ensuring good end of life care for older adults and their family members.
5. References


6. Appendices

Appendix A - PEACE tool
Appendix B - PACE tool
Appendix C - Consent form
Appendix D - Participant Information Sheet
PEACE model principles.

1. Patient identified who would benefit from developing Peace plan in discussion with the care home/ following recent admission

2. 1st discussion takes place led by admission avoidance care homes matron

3. Provide patient/family, staff information-

4. Admission avoidance care homes matron can draw on support from GP, Care of Elderly consultant, EOLC specialist on as required basis.

5. ALL plans signed by GP, Care of Elderly consultant, EOLC specialist

5. Share plan via proactive care MDT coordinators/ GP. Identify key worker and plan uploaded to IBIS / one call.

6. Review plan as appropriate to individual circumstance.

<table>
<thead>
<tr>
<th>Care home</th>
<th>New Grange (Care home)</th>
<th>Aldersmead (Nursing home)</th>
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<tbody>
<tr>
<td>Admission avoidance care home</td>
<td>Ria Evans</td>
<td>Sonja Rosell/ Fiona Stevens (from Feb 2015)</td>
</tr>
<tr>
<td>matron</td>
<td></td>
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<tr>
<td>Supported by GP champion</td>
<td>Bikram Raychaudhuri (until Feb 2015)</td>
<td>Beth Meek</td>
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<tr>
<td>Consultant Care of the Elderly</td>
<td>Tom Saunders</td>
<td>Jackie Pace</td>
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<td>support</td>
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<tr>
<td>End of Life specialist support</td>
<td>Suzanne Ford- Dunne</td>
<td>Brendan Amesbury</td>
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</table>
**Proactive Anticipatory Care Plan (PACe) Documentation**

**Personalised Care Management Plan**

To be used for any patients where Proactive Anticipatory Care or End of Life Care is being discussed and documented

<table>
<thead>
<tr>
<th>Start Date:</th>
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<td>Optional Review Date:</td>
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This plan should be reviewed by GP/Consultant/Community Matron if clinically indicated. The professional making any changes must inform all holders of the plan.

<table>
<thead>
<tr>
<th>Current Living accommodation</th>
<th>Own Home</th>
<th>Supported Living</th>
<th>Residential Home</th>
<th>Nursing Home</th>
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**Person’s Details**

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<tr>
<th>Person's name:</th>
<th>Date of birth:</th>
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<td>Address:</td>
<td>Phone number:</td>
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**Next of Kin Details**

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<th>Relationship:</th>
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<td>Address:</td>
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**G.P. Details**

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<td>Address:</td>
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**Consultant Details**

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**Family Emergency Contact Details**

To be contacted if significant changes in patient care occur

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<th>Contact name:</th>
<th>Relationship</th>
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1.0 Completion of this Document

Completion of the Proactive Anticipatory Care Plan (PACE) documentation should form the basis of a treatment plan to support people with end of life care needs.

It is intended to provide a framework by which patients, families, carers, and medical professionals, can work together to plan care in the patient’s best interest. This allows the delivery of care in line with the person’s advance care plan (where present), preferences, values, wishes or beliefs.

1.1 Looking after this record

☐ Once completed, keep this record in a prominent place.

1.2 Ensuring continuity of care

☐ Once completed, ensure the information is registered with and approved by the primary care physician and coded appropriately in the patient’s medical record (Use read code 8CME).

☐ Record the existence of the PACe documentation on the SPN

☐ Send SPN to OOH

☐ PACe paperwork to remain with patient at all times and during transfers of care provision

☐ Share it with the wider health team within the community.

☐ Make the information readily available to visiting health professionals.

☐ Share with all involved in the decision making process; including patient, family and/or advocates such as an Independent Mental Capacity Act representative.

We understand that to ensure effective care the contents of this document may be shared

For Patients who have capacity :-

I ................................................................ give permission for you to share my information with relevant clinical teams to ensure I have effective care

Signature :.................................................................

I give permission for you to discuss my care needs with members of my family :-

Signature ..............................................

I refuse permission for you to share my information with members of my family

Signature ..............................................

For Best Interest where the patient does not have capacity we agree to share information with relevant agencies as required
Proactive Anticipatory Care (PACE)

Suggested Action on Progression of Illness

3.0 Main diagnosis:

3.1 Summary of significant previous medical history:

3.2 Medication List and allergies

Please ensure an up to date list of medication is attached to this document

3.3 People involved in the decision making process and in my ongoing care e.g. a doctor / family / person

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
<th>Phone</th>
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*when drawing up this care plan

K Fisher  Review date   May 2015

Amended  08/10/2014 Version 4
3.4 My views

You must consider if I have capacity to make decisions regarding my care at this point (to ensure this is done in accordance with current legislation, please see appendix 1 MCA Guidance).

3.5 Questionnaire

*Please circle the appropriate Y/N response.*

Does the Patient have any specific Communication difficulties or disability that will require reasonable adjustment for the assessment and ongoing care delivery?  
Yes  No

Please Specify: -

Have you assessed this person’s capacity to make decisions regarding their care?  
Yes  No

Does the person have mental capacity to decide about the actions if their illness progresses?  
Yes  No

Does the person have an Advance Care Plan?  
Yes  No

Date reviewed....................

Does this person have a Lasting Power of Attorney for Health and Well-being?  
Yes  No

Held By .........................

Advance directive to refuse treatment?  
Yes  No

Held By .........................

**Do Not Attempt Cardio-Pulmonary Resuscitation documentation (DNACPR)?**  
Yes  No

Court appointed deputy?  
Yes  No

Name: -

Contact Details: -
3.6 Discussion summary regarding End of Life Care

Summary of discussion including views of significant others, to include next of kin, advocate and or Independent mental capacity Act (IMCA) as required. Please note the key content of the discussion areas here. This must take note of differing opinions which may be relevant to future best interest decision. Continue on separate page if necessary.

3. 7 Spiritual needs of the patient at the end of life:

3.8 Preferred place of care:

3.9 Preferred place of death:
4.0 Assessment
This section should normally be completed by the patient’s usual GP in keeping with best interest. If the patient is in hospital the consultant may lead the initial completion. This advice may not be applicable if the situation changes, and should be used in conjunction with assessment and views of the patient and others at the time.

### Anticipatory Care Plan

<table>
<thead>
<tr>
<th>Possible developments specific to the person e.g. chest infection</th>
<th>Action Category (see 4.1 below)</th>
<th>Comments</th>
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<td>7 Serious unexpected event.</td>
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<td>8 Suspected Fracture of major bone</td>
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<td>Transfer to hospital or if transfer felt inappropriate obtain immediate consultant orthogeriatric advice</td>
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<td>8 Patient has no signs of life.</td>
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4.1 Action categories

Intensive:
Transfer to hospital for treatment if appropriate. Intubation, ventilation etc. should be considered.

Hospital:
Transfer to hospital for treatment if appropriate. Hospital staff should be aware of the patient’s best interest in considering any intensive level treatment.

Home:
Treatment, medication and comfort measures within the community with support from GP. Admission to hospital would be avoided unless comfort measures fail.

Comfort:
Palliative Medication by subcutaneous, oral or per rectal route, positioning, wound care and other measures to relieve suffering. Admission to hospital would be avoided unless comfort measures fail (e.g.: fractured neck of femur).

Signatures of those involved in the care planning process

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<thead>
<tr>
<th>Role</th>
<th>Signature</th>
<th>Printed Name</th>
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<td>Consultant</td>
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<td>Care Team</td>
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<tr>
<td>Relative</td>
<td>Signature</td>
<td>Printed Name</td>
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Signature optional. If not signed indicate name of relative consulted.
Major changes to treatment plan following review:

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<th>Action Category</th>
<th>Comments</th>
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This Document is based on an original care plan (PEACE) originally developed at Kings College Hospital London and St Thomas’s Hospital and has been adapted with kind permission for use in acute, primary and community care.
Appendix 1

Mental Capacity refers to:-

☐ The ability to make decisions that affect daily life i.e. what time to get up, whether to clean your teeth, what to wear, whether to go to the doctors – as well as more serious significant decisions.

☐ It also refers to a person’s ability to make a decision that may have legal consequences for them or for others this includes serious medical treatment, buying goods or making a will.

When supporting people to make decisions you must always

☐ Assume person has capacity unless proved otherwise

☐ Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them

☐ A person should not be treated as incapable of making a decision because their decision may seem unwise

☐ Always do things or, take decisions for people without capacity, in their best interests

☐ Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

The two-stage test of capacity

☐ Is there an impairment of, or disturbance in, the functioning of the person’s mind or brain?

☐ If so, is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision

This two stage test should be used and your records should show it has been used

Assessing Capacity

When giving consent to treatment or intervention the person needs to:-

☐ Understand the information

☐ Retain the information

☐ Weigh up the information to make decisions

☐ Communicate the decision

Best Interest Decisions

☐ Should not be made until a full capacity assessment shows that the person does not have capacity

☐ Should not be based on age, appearance condition or behaviour

☐ Should encourage views of patient, families and other professionals

☐ Take into account prior wishes and feelings, this may be gained through an advanced care-plan or advanced directive
Appendix 2

1.0 Proactive Advanced Care: Guidance for Care Homes

If your patient deteriorates and has a suggested action of 'intensive' or 'hospital' treatment, then the appropriate action is to ring the GP /out of Hours / 999 and if necessary arrange admission to hospital.

If your patient deteriorates and has a suggested action of 'comfort' or 'home', you may find the following grids helpful. In order to carry them out, you may need to ask the GP to come to see the patient and to prescribe as appropriate, and involve the support of the District Nurses, Community Matrons or Palliative Care Teams.

Contact the patient's significant others as stated on the front of this form.

1.1 Guidance Notes

In case of deterioration, it is important to exclude simple and reversible causes e.g. constipation, urinary retention.

These are possible developments specific to a person which could be considered when completing the plan:

• Severe infections e.g. pneumonia, urinary tract infection

• Dysphagia, aspiration pneumonia

• Blood tests and routine investigations

• Hospitalisation for specialist diagnostics e.g. scans, x-rays

**Fracture of major bone**

Take immediate orthogeriatrician advice

And/Or

Transfer the patient to hospital

• Action to be taken in case of a sudden serious illness, stroke or suspected heart attack
1.2 Check Box

<table>
<thead>
<tr>
<th></th>
<th>Home</th>
<th>Comfort</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feeding</strong></td>
<td>Oral food as tolerated (e.g. pureed). If required involve community SALT</td>
<td>Oral fluids or food as tolerated.</td>
</tr>
<tr>
<td><strong>Hydration</strong></td>
<td>Oral fluid as tolerated. If required follow SALT advice. Where possible / appropriate you may use sub-cutaneous fluids in the care home.</td>
<td>Oral fluids or food as tolerated and as often as tolerated. Low intake is very likely.</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td>Contact GP for diagnosis and treatment with antibiotics if required.</td>
<td>Treat symptoms as required. Fan therapy for temperatures.</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>If new pain GP may need to consider the diagnosis, and treat accordingly.</td>
<td>Call GP / Palliative care team if involved. Consider medication. Oromorph or sub-cut morphine may be required.</td>
</tr>
<tr>
<td><strong>Breathlessness</strong></td>
<td>GP will need to consider cause of breathlessness and what treatment medications are appropriate.</td>
<td>Call GP/Palliative care team if involved to consider medication options. Consider oxygen, normal saline nebulisers.</td>
</tr>
<tr>
<td><strong>Agitation</strong></td>
<td>Ensure no urinary retention/ constipation / pain or other unmet need Call GP to prescribe sedation if required. Consider environmental alterations.</td>
<td>Ensure no urinary retention/ constipation/ pain or other unmet need. If necessary call GP to prescribe medication.</td>
</tr>
<tr>
<td><strong>Nausea / vomiting</strong></td>
<td>Check no constipation / urinary infection and treat accordingly +/- antiemetic.</td>
<td>Check no constipation. GP will need to prescribe anti-emetics, e.g. cyclizine oral or s/c</td>
</tr>
</tbody>
</table>
### Diarrhoea
- Check not overflow constipation (PR).
- Stool samples for c.difficile and treatment if positive.
- Encourage fluids.
- Loperamide only if continues for more than 3 days and risk of skin breakdown.

### Drowsiness / confusion
- Check for constipation / urinary infection / dehydration.
- Consider medications which could be causing this.
- The GP may need to do blood tests to guide therapy.

### Fall
- Examine for injury.
  - If fracture suspected may require admission to hospital for adequate palliative management or operative stabilization.
  - Give analgesia prior to transfer.
  - If no injury, consider cause of fall.
  - Consider need for crash mats, low bed, increased supervision and assistance with toileting and transfers.

### Medications
- Consult with GP if patient is refusing to take oral medication
- Ask GP/Palliative care if involved to review medications, especially to stop unnecessary medications.

### Pressure area care
- Pressure area care is based on risk assessment and is fully documented.
- Patient repositioning should be maintained ensuring that pain issues are also addressed.
- Pressure sores managed at home with review by Tissue Viability Nurse and GP.

In addition, pressure care, mouth care, management of continence issues, and spiritual well-being will all be important.

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This document has been adapted for use across primary care, community and acute care settings, from the original PEACe paperwork with kind permission of Guy’s and St Thomas’s Hospital.
PEACE STUDY: TELEPHONE INTERVIEW CONSENT FORM- Care Staff

Professor Pat Schofield, Professor of Nursing & Dr Gary Bellamy, Research Fellow, University of Greenwich.

1. I confirm that I have read and understand the information sheet dated January 2015 (version 1) for the above study and have had the opportunity to ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my employment rights being affected.

3. I agree to participate in a telephone interview with a researcher and understand that this may be digitally recorded and transcribed.

4. I understand that data collected during the study may be looked at by responsible individuals from the University of Greenwich, where it is relevant to my taking part in this research.

5. In the event that any poor care is reported by staff during the course of the interview, I understand that the researcher has a duty to report this to the appropriate NHS Trust collaborator.

6. I understand that any information gathered from the interview may be included in academic publications and that all information will be carefully anonymised prior to publication. No material which could identify me will be used in any reports based on this study.

7. I agree to take part in the above study

________________________________________  __________________________  __________________________
Name of Participant                        Date                                 Signature

________________________________________  __________________________  __________________________
Name of Researcher                        Date                                 Signature

(1 copy for participant, 1 copy for researcher)
INFORMATION SHEET- Healthcare Professionals
PEACE RESEARCH STUDY

You are invited to take part in a study that is being conducted by researchers based at the University of Greenwich. The study is funded by the Academic Health Sciences Network Kent, Surrey and Sussex.

Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Your participation is entirely voluntary (your choice). You do not have to take part in the study. If you do agree to take part, you are free to withdraw at any time, without giving a reason. To help you make your decision, please read this information sheet carefully. You may take as much time as you like to consider whether or not to take part in the study. If you do agree to participate you will be asked to sign a consent form, a copy of which you will be able to keep.

What is the purpose of the study?
PEACE (Proactive Elderly Advance CarE) enables advance care planning (ACP) discussions to be held and was developed at two acute hospital sites in London, UK, for care home (nursing) residents prior to discharge. Patient preferences are documented, or in the case of mental incapacity, best interest decisions are made, to provide clinical advice and guidance for future health care. Across Kent, Surrey and Sussex these conversations are led by different healthcare professionals. You have been selected to participate in this study because you are a healthcare professional involved in advance care planning discussions with patients and the research team are keen to explore your views and experiences of using this document and having these conversations with patients and family carers.

Do I have to take part?
No, it is up to you to decide whether or not to take part. You will be given this information sheet to keep and be asked to sign a consent form and complete an anonymous demographic form. You will be asked to sign a consent form before you take part in the study. If you decide to take part you are still free to withdraw at any time, and a decision not to take part will not affect your rights as an employee.

What will I have to do if I take part?
It will involve participating in a short telephone interview with a trained researcher. You will be asked about your thoughts and feelings about PEACE as a tool for advance care planning conversations and your views about the most appropriate member of the team to hold those conversations with patients.

Where will the interview take place?
The interview will take place at a location of your choice and on a convenient date and time to you. The interview will take approximately 30 minutes to complete.

What are the possible disadvantages and risks of taking part?
Taking part in the study will take some of your time and require you to answer a series of questions during the course of the discussion. There are no particular risks or disadvantages associated with taking part in this study.
What are the possible benefits to taking part?
Your involvement will give you the opportunity to express your views and opinions regarding advance care planning discussions with patients. Your involvement may also help to inform the future care and treatment that other people receive.

What if something goes wrong?
If you are harmed by taking part in this research project, there are no special compensation arrangements available. Any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study should be raised with the principal investigator.

Will the interview be recorded?
Yes. With your permission, the interview will be recorded. These recordings will be stored on a password protected computer at the University of Greenwich and only members of the research team will have access to them. They will be transcribed by an individual who is aware that the information is confidential. No material that could personally identify you will be used in any reports from this study.

Will my taking part in this study be kept confidential?
Information provided during the interview will be confidential. If the information provided is included in a report or published, this will be done in a way that does not identify you. Consent forms and any other details collected by the research team will be stored in a locked cabinet on University premises. These will be securely destroyed (shredded) once the study has been completed.

What will happen to the findings from study?
Findings of the study will be available in 2015 and a copy of the report will be available if you wish to read it. Your name will not be used in the report or any subsequent publications. A collaborative learning event to share practice across Kent, Surrey and Sussex will also take place which you will be invited to.

Who is funding the research?
The study has been funded by the Academic Health Sciences Network of Kent, Surrey and Sussex.

Who has reviewed the study?
This study has been reviewed and given a favourable opinion by the University of Greenwich Research Ethics Committee (reference FREC/EH/14-003 BELLAMY).

Contact for further information:
Dr Gary Bellamy
University of Greenwich
Department of Adult Nursing and Paramedic Science
Avery Hill Campus
Eltham, London, SE9 2UG
020 8331 8885 / g.bellamy@greenwich.ac.uk

Thank you for taking the time to read this information sheet and considering taking part in the study.