Galashiels Health Centre

Anticipatory Care Plan Project

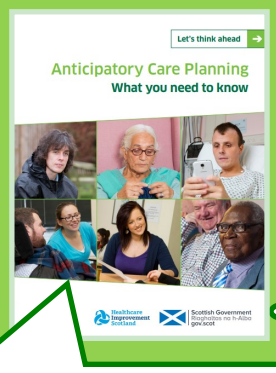
Increasing the use of Anticipatory Care Plans (ACPs) by 50% within the Galashiels Health Centre (GHC) patient population

Thinking ahead – What matters to me? **Thinking ahead – What matters to me?** **Thinking ahead – What matters to me?**

Trialling the Healthcare Improvement Scotland (HIS) ACP document in 2 practices within the Galashiels Health Centre patient population

METHOD

GP visits to 9 patients requiring an ACP. Chosen from a list of suitable patients from 2 practices within GHC.
Each patient was given the HIS ACP pack and visited twice, on one occasion with a relative or carer present.
Following this, each patient and carer was asked to complete a questionnaire about the HIS ACP pack and their ACP experience.



"It was very helpful for my husband, son and daughter to know what I want for my future" **Patient**

"It is good to know my wife's mind on these matters to assist making difficult decisions in time of emotional stress" **Carer**

concerns over additional work involved in compiling these ACPs in Primary Care. **GHC GPs**

RESULTS

"I thought it was very helpful and it has all my details if I took ill" **Patient**

"I developed an "eKIS update sheet" which was useful to record the information gained whilst visiting patients so that ACP information could be transferred to OOH and Secondary Care electronically" **Project GP**

Anticipatory Care Planning – it's everyone's business **Anticipatory Care Planning – it's everyone's business**

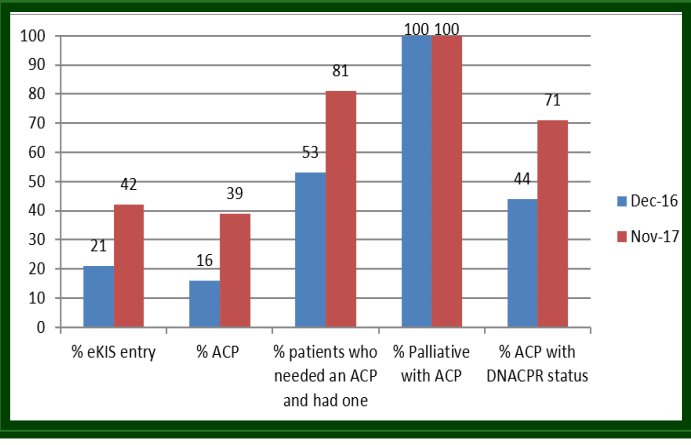
Improving the quality & quantity of data entered into the electronic Key Information Summary (eKIS) throughout the GHC patient population (approximately 14,600) by December 2017

Baseline audit:
57 patients who had made an out of hours (OOH) contact during December 2016 were randomly selected. This was just under 25% of all OOH contacts for GHC.

Interventions:
Results were discussed with GPs: recommendations made to GPs (see below)

Promotion of ACPs: Primary & Community Services newsletter - GP cluster leads - Eildon locality group from the Health & Social Care partnership - attendance at Borders carers event - Central district nurse team - Galashiels social work team.

Patient Profiles
64% were over 70 years old
55% were on 5 or more prescribed medications
83% had 3 or more co-morbidities (complex)
31% were receiving palliative care



Test of Change audit:

A further 57 patients who had made an OOH contact during November 2017 were randomly selected.

Results

- **100%** increase in the use of eKIS
- **53%** increase in ACPs
- **61%** increase in the number of DNACPR status recorded
- **25%** increase in the number of dated special notes

100% eKIS & ACPs for Palliative Care patients

Working together, Improving outcomes **Working together, Improving Outcomes** **Working together, Improving Outcomes**

Anticipatory Care Planning is a journey not a one-off event and should keep the patient in the centre and involve all health and social care professionals (HSCPs). Those HSCPs with frequent patient contact are in the best position to discover what matters to the patient.

If each HSCP adds information to the ACP then the burden is shared and the ACP is useful and up to date e.g. Social services states package of care/Physio states mobility issues/District nurse enters information re: DNACPR following a discussion/ hospital doctors provide information re future management of a recurrent problem (all currently through the GP via eKIS)

Electronic access to up-to-date ACP information allows patients to be treated appropriately in their preferred place of care. Further work could test whether the eKIS update sheet could be used in the situations listed above. **Would this model work for you?**

Key Information Summary Update sheet

NAME: DATE OF BIRTH: CHI NUMBER:	ADDRESS:
CONSENT discussed and given for sharing this information with health & social care professionals	YES NO Delete as appropriate
IN CASE OF EMERGENCY....	Access issues:
Contact 1:	Phone: Relationship:
Contact 2:	Phone: Relationship:
MAIN CARER DETAILS: Preferred place of care:	Contingency plan if carer unwell:
DIAGNOSES:	
PROGNOSIS:	Is patient aware? YES/NO Are relatives aware? YES/NO Delete as appropriate
POWER OF ATTORNEY NAME: Contact details if not listed above:	Welfare? YES/NO Financial? YES/NO Delete as appropriate
SPECIAL NOTE Key treatment and concerns in an emergency? Usual functioning e.g. O2 saturation Oxygen at home? Mobility issues? Equipment? Continence issues? Communication issues? Behavioural/Mental health issues? Medication issues? Escalation plan in event of deterioration?	
RESUSCITATION STATUS	Discussed? YES/NO Form in place YES/NO Delete as appropriate
Name of professional completing form:	*Signature:*
Role:	*DATE:*

Five eKIS Interventions for EMIS users that improve the transfer of information:

1. Place the date at the start of any text in your special note (tab 0)
2. Do not add an expiry date to the special note – use the mandatory KIS review date to alert you of the need for a review (The SN cannot be accessed by OOH after the expiry date!)
3. Try to include baseline functioning and what to do if the patient deteriorates
4. Pull through key diagnoses from EMIS into eKIS (tab 2)
5. Make sure there are contact details available for next of kin/carers – this is not relevant if the patient is in a care home, as they will have the details.

Acknowledgements:
Scottish Government Recruitment & Retention Funding
Galashiels Health Centre GPs
QI mentors: Mags Baird (Project manager NHS Borders) and Dr Rebecca Green (Clinical Lead for Borders Emergency Care Service)
Healthcare Improvement Scotland for all their foundational work with Anticipatory Care Planning

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