# Implementing plans for treatment and care in a future emergency: what are the implications for nursing roles and nursing practice?


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# Context: NIHR CLAHRC Wessex

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- 5 year research and implementation programme funded by the NIHR.
- Partnership between local NHS providers, commissioner, patients/public and academic researchers.
- Aims to bridge the gap between research carried out by academics and its implementation on NHS frontline to impact on lives of patients and families and quality of service they receive.
- Focus is on research that benefits people living in Wessex through better integration of pathways of care for people with long-term conditions, and reduce hospital admissions, through more appropriate use of care.

# NIHR CLAHRC Wessex *Complexity at End of Life* Research Programme

National Institute for Health Research

## OUR FOCUS

- People with complex and co-morbid conditions, including those towards end of life and whose management moves back and forth between primary and secondary care.
- Developing and testing interventions that mobilise patient preferences, reduce complexity and burden of treatment.
- Utilising theoretical models to promote and implement change across healthcare services.

## OUR RESEARCH

- Development, implementation and evaluation of *complex* and *contentious* health care interventions, focusing on Treatment Escalation Plans (TEPs) as a mechanism for improving decision-making about treatment and care in a future emergency and in the event of deteriorating health.

# What are contentious interventions?

- Have a moral purpose and value.
- Contain elements seeking to routinise highly complex clinical skills, practice and different types of knowledge in a context of uncertainty.
- Contentiousness can arise because the intervention relies on:
  - patient, family and clinical interactions
  - inter-clinician interactions (potentially across clinical settings & organisational boundaries)
  - societal and legal frameworks e.g. MCA (2005) European Convention on Human Rights (2002)
- Examples of CIs could include: discharge planning, sedation at end of life, artificial nutrition and hydration.

# Background

- People facing end-stage disease or at risk of clinical deterioration may find it difficult to communicate their wishes about their care.
- Currently only 4% of people discuss the type of care they would or would not like to receive in an emergency.
- At such times of crisis HCPs often make numerous and challenging treatment decisions, with little information available to take account of patient preferences, in context of clinical uncertainty.
- Increasing evidence supports the need and desirability of documenting a care plan addressing options about treatment escalation which minimise risk of potential harm from unwanted and futile investigations and treatments.

# Treatment Escalation Plans (TEPs)

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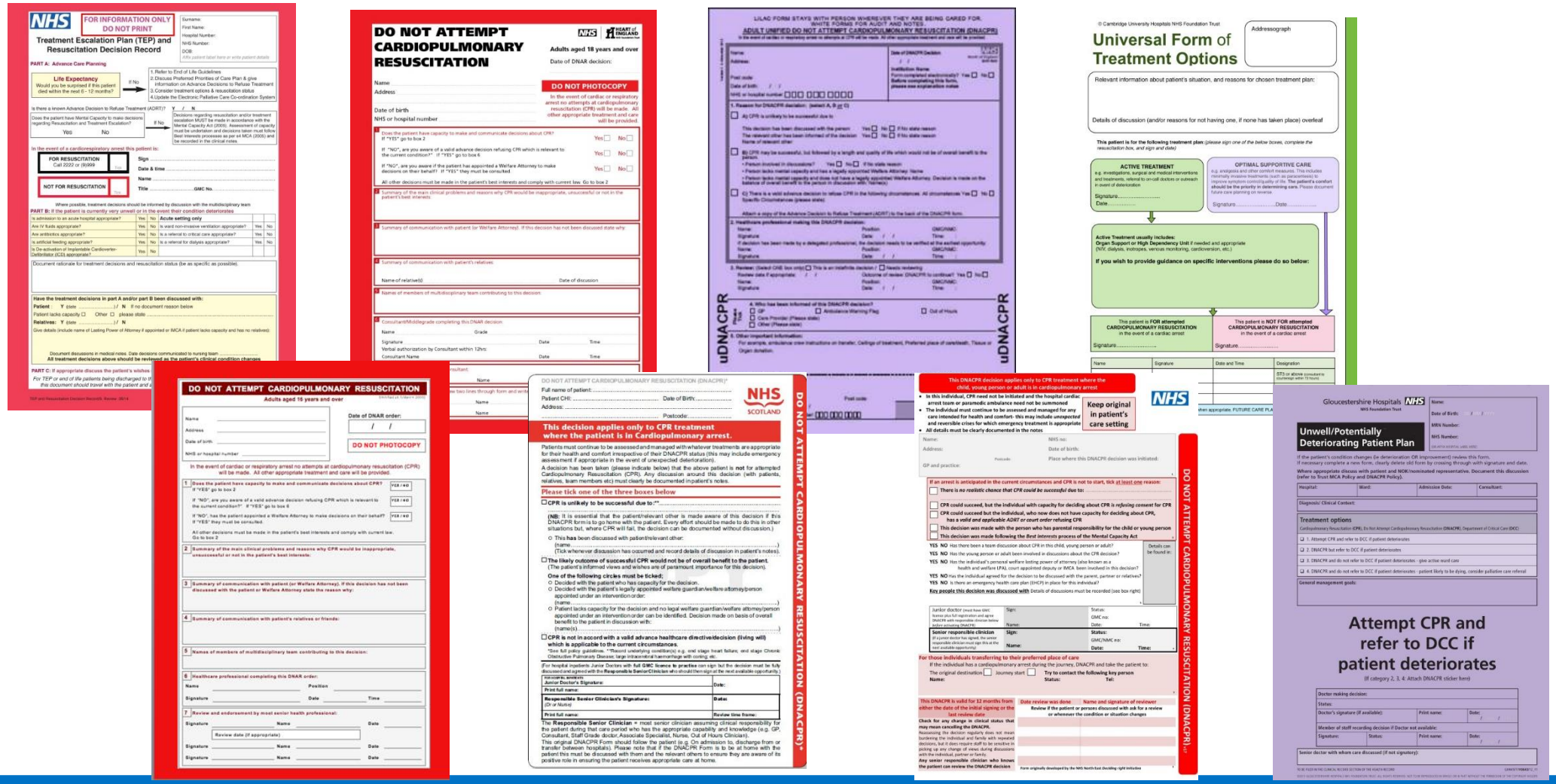
- Treatment Escalation Plans (TEPs) have been in international use since the 1990s e.g. USA, Australia. (POLST, Goals of Care)
- In the UK first TEP was introduced in 2010 – Devon TEP.
- TEPs vary in design and use in UK, but are defined by offering an individualised plan for communicating decisions regarding treatment and care options.
- Means to facilitate shared decision-making, ensure patient preferences are considered.
- Provides essential reference point in a crisis situation facilitating transfer of information across clinical settings.
- ***More than just a form*** … underpinned by a process to enable positive conversations about treatment actions to be pursued and agreement about other options, including CPR, that may be unwanted or inappropriate.

# Examples of TEPs in the UK: a confusing landscape

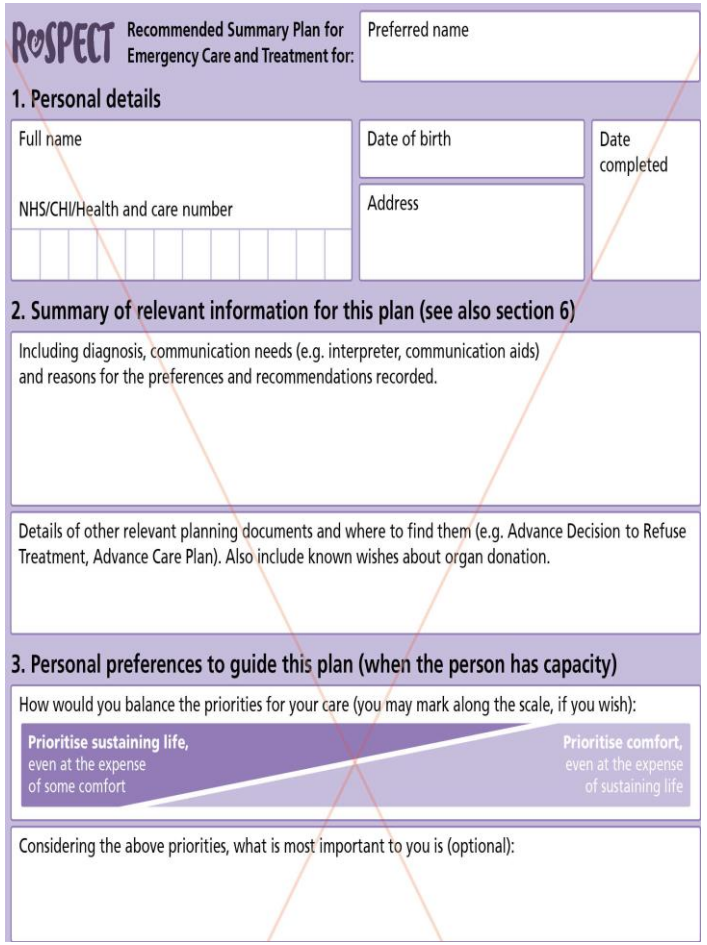


# Towards a national process …

- Findings presented from a systematic review (Perkins et al) showed DNACPR decisions had been associated with:
  - negative public/patient perceptions
  - negative clinical perceptions
  - source of legal concern and ethical challenge
  - negative media reports.

- In 2014 work commenced to develop a national document and process, led by Resuscitation Council (UK) and RCN
  - discuss resuscitation in broader context of care
  - national (standardised) documentation recognised by all.

- In Feb 2017 **ReSPECT** (Recommended Summary Plan for Emergency Care and Treatment) published
  - no mandate
  - local Wessex implementation in Hampshire Hospitals Foundation Trust (Basingstoke & Winchester hospitals) - Sept 2017


ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:
Preferred name
1. Personal details
Full name
Date of birth
Date completed
NHS/CHI/Health and care number
Address
2. Summary of relevant information for this plan (see also section 6)
Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.
Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.
3. Personal preferences to guide this plan (when the person has capacity)
How would you balance the priorities for your care (you may mark along the scale, if you wish):
Prioritise sustaining life, even at the expense of some comfort
Prioritise comfort, even at the expense of sustaining life
Considering the above priorities, what is most important to you is (optional):

# Overview of the TEPs study: service development & research

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- The **service development** work involved collaborations with NHS partners in acute Trusts, primary care, an ambulance Trust and Nursing home as well as patient and public contributors affected by life limiting, long term conditions in the Wessex region.
  - Each participating Trust/service was asked to establish a working group, chaired by a lead clinician, to consider the appropriateness, challenges and benefits of implementing a TEP in their organisation. All groups were multi professional.

- The **research** component is concerned with evaluating the implementation process of TEPs as they begin to be rolled out.
  - Involved exploring sources of variations in take up and sustainability across organisations, and identifying factors that impede or facilitate implementation.
  - Required understanding the implementation journey of TEPs, how the intervention crosses the translational gap between research and evaluation into everyday clinical practice and understanding the organisational context with which it interacts.

# DESIGN AND METHODS

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- Qualitative design using semi structured interviews and observational field notes.
- 37 interviews with a range of HCPs (senior nurses/consultants and registrars /GPs/ambulance personnel)
- 3 acute Trusts, 1 ambulance Trust, 1 GP practice, 1 hospice, members of the national ReSPECT Working Group and NHS England South.
- Field notes from observations of working groups, 46 hours of observation carried out over a 24 months.
- Normalization Process Theory (May & Finch 2009)* provided theoretical lens for the study.

* May C, Finch T. Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology*. 2009;43(3):535–54.

# Normalisation Process Theory (NPT)

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- Mid-range theory to investigate and understand the process through which interventions are operationalised in healthcare settings and incorporated into everyday practice.
- Identifies, characterises and explains mechanisms that have been empirically demonstrated to motivate and shape implementation processes and affect their outcomes.
- Focuses on four dynamic processes that motivate and shape implementation processes.
  - **Coherence**
  - **Cognitive participation**
  - **Collective action**
  - **Reflexive monitoring**

# How did NPT help to understand and explain nursing roles and practice in implementing TEPs?

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- **Coherence** – sense-making work undertaken by nurses individually and collectively to understand the extent to which TEP is meaningful, achievable and necessary.

- **Cognitive participation** – work undertaken by nurses to assess degree of ownership of and participation in the implementation of TEPs.

- **Collective action** –work nurses carried out to enact TEP implementation.

- **Reflexive monitoring** – appraisal work carried out by nurses to explore perceived impact of TEP on staff work and patient outcomes.

# Findings
# Coherence: making sense of TEP implementation

- Most nurses could see how TEP differed or complimented existing practices which was important for supporting implementation.
- Identified benefits of TEP both for patients/families and their own clinical practice.
- **Patients and families**
  - Means of empowering the patient voice, promoting patient autonomy
  - Offers shared decision-making between patient/family/clinician and ensures patient preferences are considered regarding treatment they may or not may want.
- **Clinical practice**
  - Guides clinical practice
  - Acts as a starting point for a discussion with patient and families
  - Reduces uncertainty in decision-making
  - Time saving

***"I think, a Treatment Escalation Plan is very valuable. I think, it's a fantastic opportunity to start having dialogue and conversations early and, also, to ensure that, as healthcare professionals we've listened, actively listened, to our patients and what their wishes and what their thoughts are and that that's clearly documented and can be shared with others".*** *(EOLC Nursing Education Lead)*

# Cognitive participation: ownership and who chose to be involved in implementation

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- Nurses were keen to participate in the implementation of TEPs within their Trust.
- Implementation was viewed as legitimate part of their role. However, often unclear who was responsible to ensure implementation happened.
- Contribution varied and degree of participation was often context dependent and related to organisational culture.
- Engaged in different roles and levels of participation within the working groups e.g. Chair, group member, leading education and training to promote buy-in.
- Targets and incentives were identified as a potential catalyst for involvement i.e. CQC.

*"Doctors 'assume' nursing involvement as a given. Nurses 'presume' doctors will not want to engage".* *(CNS)*

# Collective action: what was the work undertaken by nurses in TEP implementation?

- ‘Natural fit’ with practice - TEP could be easily integrated into their existing practice or were willing to adapt practice where required.
- Applied appropriate implementation knowledge and skills.
- Demonstrated awareness of own and others’ competence for discussion and completion of TEP.
- Identified appropriate patients for TEP and initiated discussions.
- Ensured TEP process completion.
- Built upon previous learning/ experience of implementing new interventions e.g. NEWS, care bundles, EOLC plans.
- Role modelling/transformational leadership/clinical credibility were also necessary.

*“I think, we are--- we are very good at trying to have those conversations and bring to the attention of the teams that we work alongside to get them thinking about: should this patient have further investigations? Or: what’s the ultimate goal here? What does the patient want”?* *(Palliative Care CNS)*

# Reflexive monitoring: appraising impact

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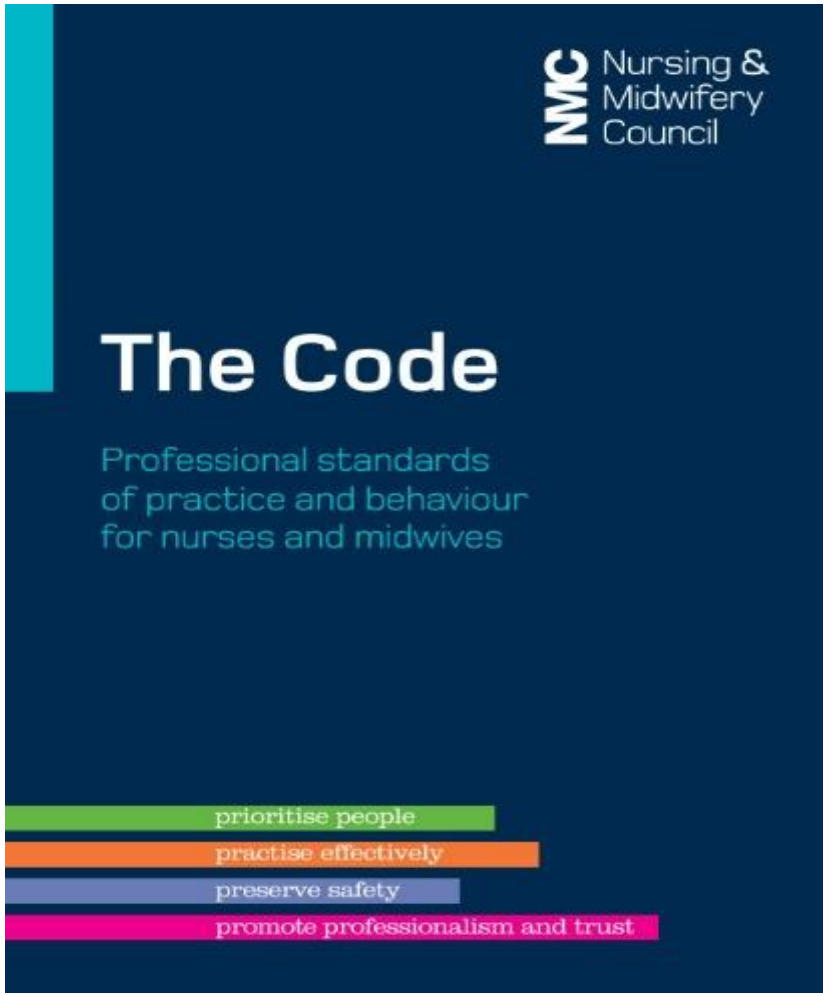
- Nurses understood the need for monitoring and evaluation of implementation.
- Awareness of evidence required to support on-going implementation.
- On-going appraisal work to explore perceived impact of TEP on staff and patient outcomes.
- Audit was recognised as a tool to highlight areas requiring further attention/training.
- Transferred previous experience of implementation to understand monitoring and evaluation required.

*"it's very much embedded now. It's in people's sort of vocabulary on the wards. It's--- it's just what people--- it's--- it's almost an automatic part of conversations on the ward and things now. It's no longer a--- a thing people need to sort of think about or think: oh, I might need to get some more information on that. It's just an automatic now".* (Matron, referring to NEWS)

# Implications for nursing roles and practice

# ‘Natural fit’ with NMC code




- **Prioritise people**
- **Practise effectively**
- **Preserve safety**
- **Promote professionalism and trust**

# ‘Natural fit’ with nursing practice: a collaborative approach enabling shared decision-making

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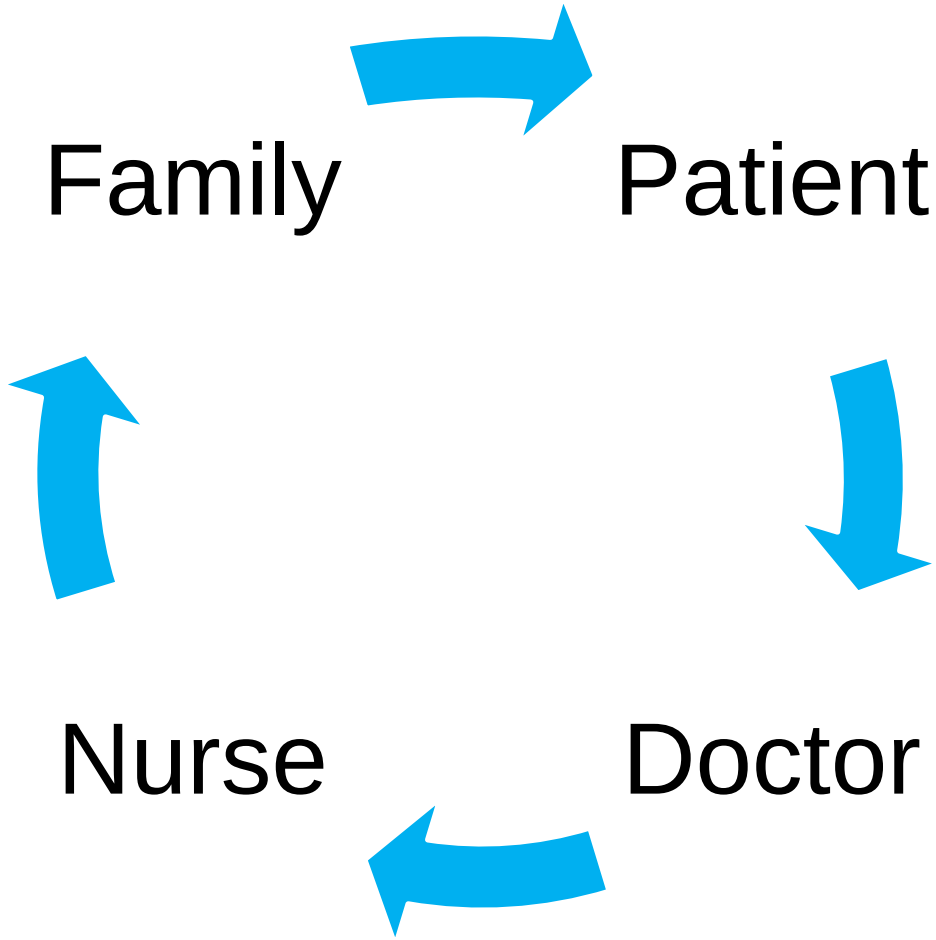

## Prioritise People

- Empowering patient voice and promoting patient autonomy
- Initiating discussions and building trusted relationships with patients and families
- Engaging in sensitive communication

## Practise effectively

- Utilising evidence to inform practice
- Utilising a TEP to guide practice
- Understanding own competence for discussion and/or completion of form
- Training and education

## Preserve safety

- Preventing harm – right patient, right treatment, right place
- Ensuring clarity and meaning of documentation
- Knowledge transfer for patient benefit

## Promote professionalism and trust

- Role modelling
- Negotiation and facilitation
- Appropriate use of resources
- Professional confidence

# Competence/competencies …

- Competence for discussion/form completion/sign off?
- Should nurses have to demonstrate competencies?
- Who judges doctors competence?
- Who assesses competence?

# In summary …

- Implementing TEP is a complex and contentious process.
- Understanding factors that impede or facilitate implementation of complex and contentious interventions, provides an opportunity to recognise the skills and knowledge nurses can contribute to the process.
- Implementation is reliant on negotiating roles and responsibilities of all stakeholders and is context dependent.
- Recognition of a transferrable knowledge base nurses possesses from previous experience of implementing other initiatives can be a contributory factor to successful implementation of a complex and contentious intervention.
- Complex and contentious nature of TEPs requires a personal commitment to them and self-confidence and professional competence for successful implementation.

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# Thank you

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