

### In this article...

- The importance of, and barriers to, discussing and recording advance care plans
- How a one-day training course increased staff confidence and knowledge in this area
- The impact training can have on staff members' practice and patients' end-of-life care

# Exploring the impact on frontline staff of training in advance care planning



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## Key points

**Timely advance care planning conversations ensure patients' wishes are met at the end of life or in the event of loss of capacity**

**Healthcare staff have reported barriers to delivering advance care planning, including time, confidence and competence**

**A study into the impact on staff of a one-day course showed that it increased confidence and knowledge**

**Some participants reported a willingness to advocate for advance care planning in their care setting**

**Even a short course can improve frontline staff's willingness and ability to engage in advance care planning**

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**Abstract** Timely advance care planning discussions and subsequent documentation are essential for optimal care. Studies have reported a lack of confidence and preparedness among frontline staff, resulting in potential delays. A study aimed to assess the impact of a one-day course on staff's perceptions of advance care planning in a range of settings. A survey was distributed following the course and the data analysed through descriptive statistics and thematic content analysis; 94% of staff felt their knowledge of advance care planning had increased and 95% felt more confident about undertaking it. Four themes were identified in qualitative responses: awareness of advance care planning, confident communication, recording and documenting, and being an advance care planning advocate. This model of delivery has reached a large number of frontline staff across multiple settings and the findings have shown the value of this course and its potential impact on clinical practice.

**Citation** Jack B et al (2020) Exploring the impact on frontline staff of training in advance care planning. *Nursing Times* [online]; 116: 11, 27-31.

Advance care planning (ACP) is central to end-of-life care policies both in the UK and internationally. End-of-life care has been subject to reports and policy drivers in recent years, and a recurring message centres around the need for education and training to ensure the workforce can provide optimal care (House of Commons Health Committee, 2015; Leadership Alliance for the Care of Dying People, 2014). In 2015, the National Palliative and End of Life Care Partnership published a framework for action, which set out six ambitions focusing on the need for honest conversation and joined-up care, supported by empathetic and competent healthcare staff.

There is growing evidence that ACP can have a positive impact on end-of-life care (Brinkman-Stoppelenburg et al, 2014) but there has been debate about how it should be defined. In 2017, an international expert

consensus panel supported by the European Association of Palliative Care reached an agreed definition: "Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals and preferences regarding future medical care" (Sudore et al, 2017).

This process may include discussions and subsequent documentation of treatment preferences and, in the event that an individual loses capacity, can result in the appointment of a decision-making proxy known as lasting power of attorney (LPA) or an advance decision to refuse treatment (ADRT) (Wilkinson, 2017). This demonstrates the need for ACP discussions and subsequent documentation to be commenced at a timely point – as does the risk of an emergency health situation, such as the current coronavirus pandemic (Ridgers, 2020).

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Ridgers (2020) argues that these conversations are especially important during this pandemic, as the survival rate among the frailest of the population is expected to be low; conversations can:

- Provide clarity about a patient's choice;
- Increase their autonomy;
- Prevent situations in which their family has to make decisions at a time of crisis.

Furthermore, although Ridgers (2020) states that nurses need to be proactive in having these conversations, she recognises the pressing need for training solutions that should be easily accessible and widely available.

This article discusses the existing research into ACP and reports on the impact of a one-day training course delivered to frontline health and social care staff.

### Literature review

A literature review revealed the following positive impacts of ACP:

- Improved communication between patients and health professionals (Bollig et al, 2016);
- Improved quality of life for patients and surviving families (Detering et al, 2010);
- Reduced number of unnecessary treatments and hospitalisations (Zwakman et al, 2018).

However, studies of health professionals, including nurses, have identified barriers to applying ACP in practice, including:

- Difficulties in approaching the subject;
- A lack of time, confidence, competence and willingness to have the conversation;
- A lack of clarity on legal issues (Fan and Rhee, 2017; Mignani et al, 2017; McGlade et al, 2017).

Cultural factors have also been implicated in the avoidance of conversations around death and dying in non-White patient populations (Aasmul et al, 2018; McDermott and Selman, 2018), and studies have shown that for an organisation to be successful in introducing and implementing ACP, full engagement is vital at leadership level (Aasmul et al, 2018; Dixon and Knapp, 2018).

### Educating the workforce on ACP

Zwakman et al (2018) stated that, due to the global development of palliative and end-of-life care, along with the expansion of ACP, there is an expectation that nurses and other health and social care staff will carry out ACP. It is, therefore, necessary that all health professionals are given the knowledge and skills to effectively engage in the process. However, the UK

undergraduate nursing curriculum currently has no standardised approach to end-of-life care, including the communication skills necessary to have effective ACP conversations (Jack et al, 2019).

### *“Barriers to applying ACP include difficulties approaching the subject, a lack of time, and a lack of clarity on legal issues”*

There is a need to carry out ACP in an evidence-based way, with guidance given to healthcare staff at all levels on how to apply this in their practice (Rietjens et al, 2016). Ridgers (2020) also argues that staff experience difficulties in initiating ACP and do not necessarily feel prepared for end-of-life discussions. However, the coronavirus pandemic has introduced a situation in which conversations about death have become more commonplace and, as such, are possibly easier to initiate.

At present, there is limited research on the impact of educating the general health and social care workforce to undertake ACP conversations and complete the subsequent documentation. However, studies have reported increased knowledge of, confidence in, and practice of ACP, following educational interventions for staff in nursing homes (Aasmul et al, 2018; Baron et al, 2015), as well as in community and acute care settings (Colville and Kennedy, 2012).

With ACP perceived to be of paramount importance in providing good end-of-life care (Zwakman et al 2018), it is essential that all frontline health and social care professionals are adequately prepared to have

these conversations. With this in mind, an ACP course was developed for frontline health and social care staff from a variety of clinical settings, including hospitals, primary care services and care homes.

### Developing and delivering the ACP course

The ACP programme was developed by the North West Coast Learning Collaborative (nwclearningcollaborative.org.uk), which provides education to support the regional end-of-life care workforce. The collaborative developed a one-day training programme on ACP and difficult communications (Table 1). Full resources and materials were included, and guidance, support, evaluation and quality assurance for the programme across the region was provided; the collaborative was however, not involved in the study reported in this article.

In 2017, nine education hubs in north-west England commenced delivery of a two-day facilitator training course based on the ‘train-the-trainer’ approach widely used in the NHS, which was designed by the learning collaborative. A hub-and-spoke model was adopted, whereby the two-day training was delivered to facilitators at central education centres before they returned to their local areas, with the aim of delivering the one-day ACP course to a minimum of 40 frontline staff from health and social care settings. The overall aim was to have 800 ACP-trained staff per location by the end of the project.

### The study

This study focused on the first cohort of frontline staff who underwent training; it aimed to assess the impact of that training on their perceptions of ACP in care home,

Table 1. Overview of the one-day ACP training

Stage	Topics covered
1. Think about it	<ul style="list-style-type: none"> <li>● ACP for people with mental capacity and anticipatory clinical management planning for people without capacity</li> <li>● The principles and application of the Mental Capacity Act 2005</li> <li>● ‘Best-interests’ decision making</li> </ul>
2. Talk about it	<ul style="list-style-type: none"> <li>● Communication about future care planning, using Jack et al’s (2013) Simple Skills Secrets model of communication</li> <li>● Role play</li> <li>● Developing conversations around ACP (scenarios)</li> </ul>
3. Record it	<ul style="list-style-type: none"> <li>● Informal and formal ACP processes</li> <li>● Recognising valid legal documents (practical documentation session)</li> </ul>
4. Share it	<ul style="list-style-type: none"> <li>● Sharing and transferring ACP information</li> <li>● The impact of not sharing ACP information</li> </ul>

ACP = advance care planning.

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community and hospital settings. Due to the large geographical region, range of settings in which sessions were held and the resource challenges, careful consideration was required regarding the study design (Polit and Beck 2017). An online survey approach was chosen; this enabled us to meet the aim of the study by including closed quantitative questions in addition to a qualitative, free-text question.

A short, confidential, electronic survey was developed, asking how the frontline staff felt about their knowledge of ACP, the course structure and content, and their confidence in having ACP conversations. Additionally, a free-text question asked them to give an example of one thing they had learned on the course that they would subsequently use in their clinical role. To keep the survey short and encourage responses, no demographic data was collected. The team had previously used similar questions for an end-of-life education evaluation (Jack et al, 2013), which meant they were confident the questions were appropriate.

As the project was deemed to be a service evaluation, it did not require NHS ethics approval by Health Education England – North West. Edge Hill University’s faculty research ethics committee reviewed the documentation and gave approval for the study. No personal or identifying data was collected through the survey.

The study participants were the first cohort of 863 staff who had undertaken the one-day training course at one of nine locations between August 2017 and June 2018. They were employed in a range of care home, hospital and community settings in the north west of England where ACP was being advocated. The survey was hosted on the North West Coast Learning Collaborative’s ACP website and staff were invited to complete it at the end of the course. Paper copies were also available. The practicality of using the electronic survey was piloted, along with the course materials, before the formal launch and was found to be effective.

### Data analysis

Descriptive statistics were used to analyse the responses to the three closed quantitative questions using a five-point Likert scale that ranged from strongly agree to strongly disagree. This quantitative data analysis was undertaken by one researcher, with a sample checked by another member of the team.

For the qualitative open question, a thematic content analysis was performed

using the methodology outlined by Braun and Clarke (2013). One researcher identified potential codes in the data, which were then further refined and developed into themes in collaboration with three other researchers; the final coding scheme was then applied to the dataset by one researcher and checked by the other three to ensure rigour.

### Survey results

In total, 248 respondents completed the survey online or in hard copy, giving a response rate of 29%. It was not possible to follow up with non-respondents as the

questionnaire did not collect demographic data or contact details.

Overall, the response was very positive: 84% of respondents strongly agreed and 10% slightly agreed that the course had improved their knowledge of ACP (Fig 1). Furthermore, frontline health and social care professionals felt more confident in their ability to incorporate ACP into their practice, with 78% (n=193) strongly and 17% slightly agreeing with the statement “the course made me more confident about doing ACP in my role” (Fig 2).

All 248 surveys included a response to the free-text question. Where respondents

Fig 1. Survey responses regarding improved knowledge of ACP

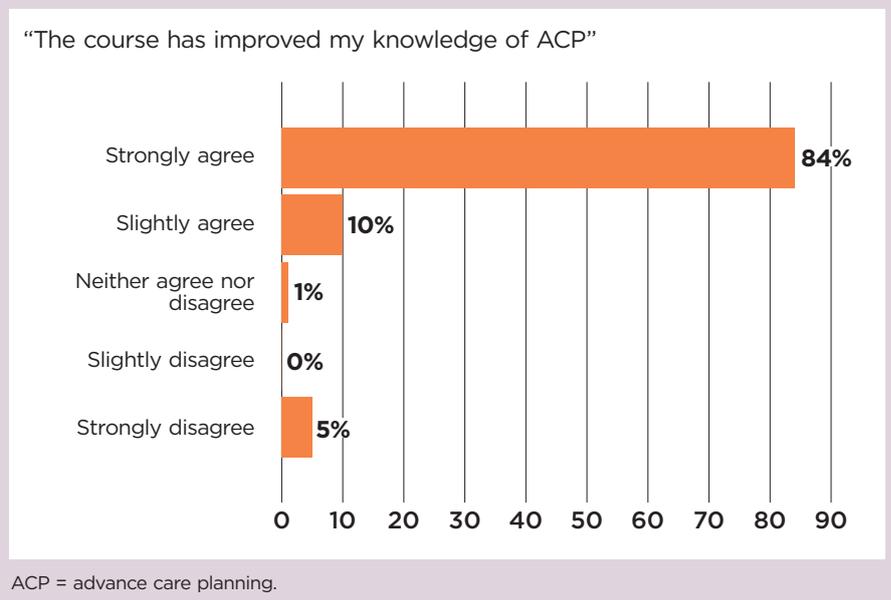
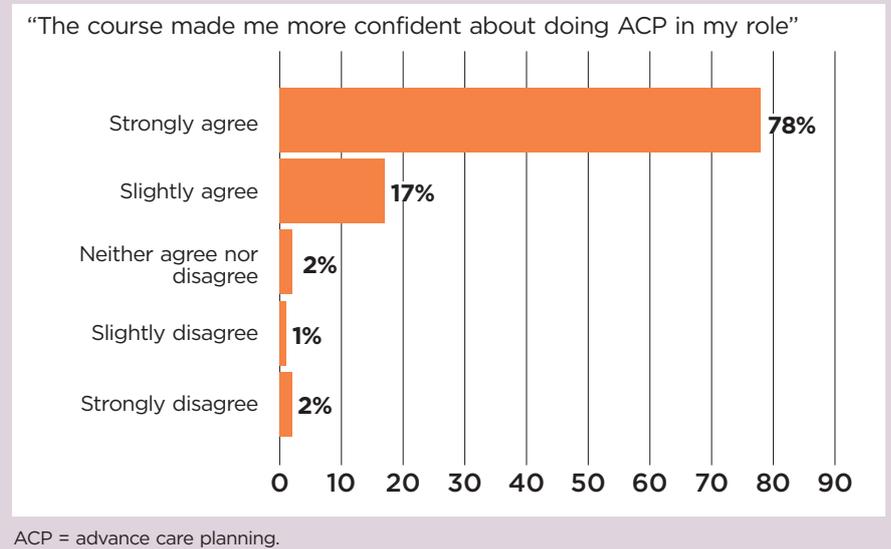


Fig 2. Survey responses regarding increased confidence to incorporate ACP into role



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made more than one point, each was treated individually in the analysis; therefore, 273 single responses to the question were analysed using thematic content analysis. This qualitative data supported the quantitative data and four themes were identified:

- Awareness of ACP;
- Confident communication;
- Recording and documenting ACP;
- Being an ACP advocate.

**Awareness of ACP.** Participants felt they were now more aware of ACP and appreciated both the importance of incorporating it into everyday practice and their role in doing so:

“[I have a] better understanding of the use and importance of ACP.” (FL204)

“[I have an] increased awareness of my role in identifying patients in the community that may be appropriate for advance care planning.” (FL56)

“[I understand] the importance of advance planning in all areas of care.” (FL226)

Additionally, participants were able to recognise:

“the difference ACP will make to outcomes for individuals at the end of life and their families.” (FL182)

and felt they now have:

“improved knowledge about ACP and how to approach patients/families with difficult questions.” (FL93)

Several responses indicated a limited previous knowledge of ACP – as such, the course had informed them of the available resources, providing:

“access to Dying Matters resources [and] increased familiarity with Gold Standards Framework resources.” (FL60)

**Confident communication.** Many respondents reported their intention to change their communication practices, either by being more confident and open to discuss future plans as early as possible, or by applying specific skills they had learnt on the course. Several respondents mentioned overcoming fears of having difficult conversations and experiencing increased confidence in initiating communication about ACP:

“The course has increased my confidence to communicate and initiate

a conversation about ACP with a terminally ill patient.” (FL6)

Some described relief following previous feelings of apprehension and a shift in perception of ACP as a difficult or taboo subject:

“ACP doesn’t need to be a daunting prospect and I’ll be more confident in applying [it] to practice.” (FL192)



The respondents identified good communication skills as crucial to ascertaining what matters to an individual about their care plan. It was also noted that, following the course, the frontline staff recognised the importance of this conversation taking place as early as possible:

“[I understand] the importance of having discussions [about] wishes/preferences early in [the] care of [a] patient.” (FL120)

Many respondents reported increased communication skills as a change to practice following the course; in particular, the use of open questions, active listening and giving patients space and time to express themselves were repeatedly referenced:

“[I have learnt] how to find cues in what a person is saying and the open questions that I can use that will help with having a conversation about advance care planning.” (FL183)

**Recording and sharing ACP documentation.** A number of respondents noted the importance of properly recording information to ensure patients’ wishes are followed in the event of a loss of capacity; there was an increased awareness of ADRT and LPA in particular, including when to use them and their appropriate legal instruments. These legal aspects were new to several of the respondents – 25 participants directly referred to legal aspects relating to ACP and an improved understanding of the legal complexities of ACP documentation was a key area that respondents stated would add to their future practice:

“[I have] a better understanding of LPA and ADRT.” (FL148)

“[I have learnt] LPA clarification and which forms need to be completed and returned before an LPA [is] fully

registered, [and the] approximate timescale of this”. (FL6)

“[I will] promote the formal aspects [of ACP] – people assume everything will be ok, but without formal documentation [it is] difficult to support someone you care for/love when they no longer have capacity/consciousness.” (FL117)

In addition to the legal documentation for ACP, several respondents identified learnings around the need to effectively share patients’ preferences with all relevant parties, including relatives and carers:

“[There are] formal and informal ways of making ACPs all-useful, but friends/family/medical staff need to be made aware of patients’ requirements.” (FL131)

**Advocating for ACP.** While the majority of respondents focused on the course’s impact on their individual practice, a small number also indicated their intention to raise awareness of ACP in their clinical setting to encourage its practice among their colleagues:

“[I will] promote advance care planning and use of advance care planning packs that are available in our trust.” (FL12)

“I will go back to my place of work and recommend the course to my colleagues, as it is a vital part of palliative/end-of-life care.” (FL115)

One respondent was so enthused following the course, they intended to make significant changes at work to improve the standard of end-of-life care provided:

“I am going to create an action plan to improve the quality of end-of-life care for residents. And include and involve people in advance care planning.” (FL231)

### Discussion

This study appears to be the first to elicit the views of a broad selection of frontline health and social care staff across a range of care settings on learning related to ACP. The response to the mode and content of delivery was strongly positive: the vast majority of survey respondents reported increased knowledge about ACP and greater confidence in undertaking it. The hub-and-spoke model used to provide the training allowed this increased awareness to be cascaded to a large number of staff, increasing ACP capacity across the region.

These findings indicate the need for, and potential efficacy of, this model.

The qualitative data analysis showed that the highest frequency of responses to the question of what respondents would take back to their professional setting referred to aspects of communication. This indicates that competence and willingness to have 'difficult' conversations, which had been reported as barriers to ACP in previous studies (Zwakman et al, 2018; Mignani et al, 2017; McGlade et al, 2017) could be addressed through this model of training.

A lack of appropriate knowledge and use of ACP documentation has previously been reported as a barrier to incorporating ACP into practice (Fan and Rhee, 2017). Survey responses highlighted an increased awareness of the types of documentation that are legally necessary and the steps involved in successfully implementing them. There is clear potential for this knowledge to have a positive impact on the recording of patients' preferences in these settings. Although fewer responses directly addressed advocating for ACP, the increases seen in ACP awareness and confidence to practise ACP – reported by a large cohort of respondents – suggests the possibility of a widespread increase in ACP use among the frontline staff trained on this programme.

The National Council for Palliative Care (2016) stressed an urgent need for high-quality end-of-life care across the various care settings. This is dependent on the generalist health and social care workforce being able to deliver it in accordance with their role and being mindful of their patients' wishes; to do this they need the

knowledge, skills and confidence to initiate ACP. Our findings suggest that, following a one-day course on ACP and having difficult conversations, frontline health and social care staff are more willing and able to incorporate ACP discussions into their everyday practice; this demonstrates the potential to improve end-of-life care.

### Limitations

The study should be interpreted in light of several limitations. Due to the brevity of the survey, data was not collected on respondents' job role, demographic information and previous ACP experience. In addition, although the data show a positive response to training and an intention to apply it to practice, it is potentially limited by self-reporting bias. To mitigate against this, further research is required to gather evidence of change in practice and patient outcomes. Further research, including pre- and post-intervention comparisons, in settings where staff have completed the training would be beneficial to evaluate any change in practice, as would longitudinal follow-up interviews with staff.

### Conclusion

To our knowledge, this study is the first one to be published that gathers responses from frontline staff who will deliver ACP across multiple settings. The results indicate that even a short training course can improve confidence and knowledge to carry out ACP, and that frontline health and social care staff perceive they have a role to play in supporting patients and families to express preferences about future care plans effectively and legally. The hub-and-spoke model, which formed the basis of the training intervention, appeared to be effective in increasing willingness and confidence among frontline staff to use ACP in their practice. **NT**

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