The Advance Project® Guide Summary

The Advance Project Guide (see the diagram on page 4) provides guidance on how general practices can systematically initiate advance care planning and palliative care with suitable patients in their practice.

The Advance Project Guide describes 3 phases for initiating advance care planning and palliative care in general practice:

1. Identify suitable patients
2. Screen for their needs
3. Evaluate patient needs.

Phase 1: How do I identify patients?

Initially, the following patients would be identified in the general practice:

- Those aged 75 years or over, for example patients attending the 75 years and over annual health assessment
- Patients aged 18 years or over with one or more chronic progressive illnesses. This includes both malignant and non-malignant conditions.

Identifying patients appropriate for advance care planning

All patients who meet the above criteria, given they are elderly or have a chronic progressive illness, would be appropriate for an early introduction to advance care planning. This could be introduced during the annual health assessment, a care plan review, or a routine consultation by a nurse or the GP using the Advance Care Planning Screening Interview or quick guide.

Identifying patients appropriate for palliative and supportive care needs assessment

Not all patients meeting the above criteria may be appropriate for palliative and supportive care needs assessment. The 'surprise' question and the SPICT™ (Supportive and Palliative Care Indicators Tool) can be used to identify a subset of these patients who may also benefit from a full assessment of their palliative and supportive care needs. These tools can be applied either opportunistically or systematically.

- Opportunistically, the GP or nurse can use time set aside for preventative care during routine consultations, health assessments, or care plan reviews to apply the surprise question and/or the SPICT™ to that patient.
- Systematically, the GP and the nurse can apply the surprise question and the SPICT to a group of patients, perhaps on a list generated through a search of the patient database for all active patients aged 75 years or over, and patients aged 18 years or over with chronic progressive diseases (e.g., you may wish to prioritise patients with congestive cardiac failure and chronic kidney disease now and get to the others later). An electronic pop-up can then be applied to the medical records of these patients to remind the GP or the nurse that they have been identified as being suitable for a full assessment of their supportive care needs.

Consider the answer to the 'surprise' question first:

> *"Would you be surprised if this patient died within the next 6 to 12 months?"*

You could ask yourself this question or discuss it with other health care professionals.

Patients for whom the answer to the surprise question is "No" would benefit from a full assessment of their supportive care needs, in addition to an introduction to advance care planning.

If the answer to the 'surprise' question is "Yes", the full supportive care needs assessment is not necessary at this stage, but the patient may still benefit from introduction to advance care planning.

If you are unsure about the answer to the 'surprise' question, the SPICT™ can be a useful aid to decision-making. The SPICT™ tool can help you to determine whether the patient might be at risk of deteriorating and dying and therefore benefit from an assessment of their supportive care needs. If

you are a nurse, you might like to discuss the patient with the GP and decide together whether the patient meets enough SPICT™ indicators for being at risk of deteriorating and dying for you both to think that a full supportive care needs assessment would be helpful. In any case, an introduction to advance care planning would still be appropriate.

Phase 2: How do I screen patients?

The second phase of the implementation guide is to 'Screen for needs'.

Screening for advance care planning needs

Advance care planning is likely to be relevant for patients aged 75 years or over, or aged 18 years or over with one or more chronic progressive illnesses, irrespective of whether they meet the SPICT™ or 'surprise' question criteria. The Advance Care Planning Screening Interview or the quick guide can be used to introduce advance care planning into a routine consultation, care plan review, or health assessment of these patients. If the advance care planning screening conversation suggests the patient is ready and interested to further discuss advance care planning, the patient could be provided with the 'Preparing for an advance care planning conversation' booklet and a follow-up consultation arranged to have a more in-depth advance care planning discussion with the GP or nurse.

Screening for palliative and supportive care needs

Patients for whom the answer to the surprise question is "No", and/or who meet the SPICT™ criteria for being at risk of deteriorating and dying, will also benefit from a full supportive care needs assessment. This assessment will help to see if the patient has any unmet needs and also help them to consider their most important concerns and priorities.

Patients who have reasonable health literacy and are well enough can be given the Advance Project Patient Assessment booklet (titled 'Supporting you to live well with a chronic illness') to complete on their own at home or possibly while waiting for an appointment.

The booklet uses non-threatening language to gently explore the person's symptoms and care needs. It does not use the word 'palliative', nor does it imply that the patient has limited life-expectancy. Hence, some practices may feel comfortable training their administrative staff to hand out the booklets to patients to complete (an example script that they can use can be found in the training package). Other practices may still prefer that the nurse or the GP discuss the need for the assessment before handing out the booklet to patients. Patients who need assistance may need an appointment with the nurse to help them complete the assessment.

The Advance Project Patient Assessment booklet includes two assessment tools:

- IPOS (Integrated Patient Outcome Scale)
- NAT-CC Patient (Needs Assessment Tool – Chronic Conditions).

Once the patient has completed the assessment booklet, the GP should review and discuss the patient's responses to the questions. This could be done as part of the doctor's component of the routine health assessment or care plan review, or as a separate consultation. In case of the latter, it is a good idea to book the patient in for a longer appointment.

If the patient is accompanied by their carer, the nurse or GP can suggest that the carer completes the Advance Project Carer Assessment booklet (titled 'Looking after you while you care for someone with a chronic illness', which contains the NAT-CC Carer tool). The carer can then make an appointment to see their own GP or nurse to review and discuss their responses.

Phase 3: How do I evaluate patient needs?

The final phase of implementation is to 'Evaluate patient needs'. Patients who are ready to have further discussions about advance care planning, based on the results of the screening conversation, should be reviewed by the GP or nurse again to discuss this. If the patient has had a chance to review

the ‘Preparing for an advance care planning conversation’ booklet prior to the follow-up consultation, this may help facilitate the discussion. More than one follow-up consultation may be needed with the GP and/or nurse to discuss advance care planning.

Patients or carers of patients who have completed the Advance Project Assessment booklets (patient and carer versions, respectively) will need to be reviewed by the GP to discuss their responses and determine an appropriate action plan. This could be done as part of the doctor’s component of the routine health assessment or care plan review, or as a separate consultation. In case of the latter, it is a good idea to book the patient in for a longer appointment.

During this review, the Advance Project Referral Triage Tool can be used to assess whether the patient’s and/or carer’s current supportive care needs can be met by the practice and support systems in place. If not, consideration should be given to whether the patient may need referral for additional support, including early referral to specialist palliative care services. Finally, it is important to consider when the patient and/or carer next needs follow-up by the general practice.

Where possible, hard copies of the completed Advance Project Assessment tools should be scanned and incorporated into the individual’s medical record. There are also RTF and fillable PDF versions of the Advance Care Planning Screening Interview, which can be incorporated into the practice software as a record of the initial advance care planning discussion.

Summary

The Advance Project Guide provides guidance for how to implement screening and assessment tools for initiating advance care planning and palliative care in general practice.

In the first phase, the nurse and the GP identify two sub-groups of patients:

- Those who would benefit from an introduction to advance care planning only (the majority)
- The much smaller group who would benefit from a full palliative and supportive care needs assessment, including an introduction to advance care planning.

In the second phase, advance care planning is introduced and the patient’s and/or carer’s supportive care needs are assessed, where appropriate.

In the third phase, the results from the patient’s and/or carer’s needs assessments are evaluated by the GP, further discussions about advance care planning are held if the patient is ready to discuss this, and any requirements for additional support are considered.

The Advance Project® Guide

Initiating advance care planning (ACP) and palliative care in general practice