BREAKING THE STIGMA: CONVERSATIONS ABOUT ADVANCED CARE PLANNING

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PROBLEM:

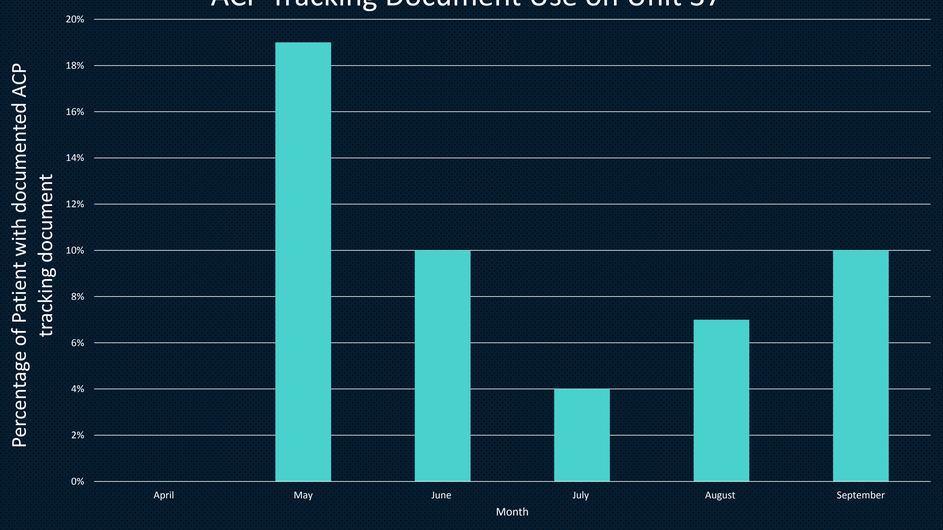
Lack of Advanced Care Planning (ACP) conversation initiation and documentation on Unit 37, leading to palliative care services being consulted too late or not at all.

BACKGROUND:

40% of patients **<75** years old experience mortality within their first year on dialysis[1]. Patients with chronic disease are often not offered palliative care services because they are not designated as "dying"[2].

METHOD:

Identified ACP champions for mentoring	Palliative care team to attend unit 37 weekly rounds	Palliative care and ACP education days and in-servicing	Printing tracking records and placing them in green sleeves at discharge	Created Palliative Model of Care



EXPECTATIONS

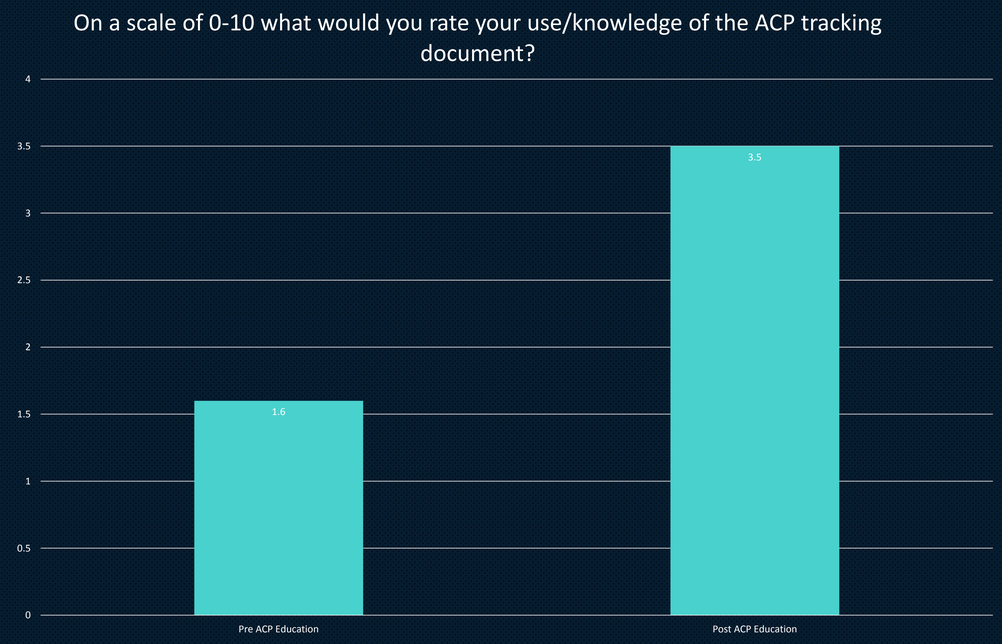
- Increase use of ACP documents
- Increase staff knowledge and comfort level on palliative care and ACP conversations
- Increase palliative care consults (average 5.7 consults per month prior to project)

SERIOUS ILLNESS CONVERSATION GUIDE

- What is your understanding now of where you are with your illness?
- If your health situation worsens, what are you most important goals?
- What abilities are so critical in your life that you can't imagine living without?

CHALLENGES AND FUTURE PLANS

- Staff buy in
- Encourage cultural shift with unit staff to make these conversations part of routine practice
- Educate new unit hires on importance of palliative care and ACP conversations
- Initiative implemented in May 2017



GOALS

- Patients and families have greater satisfaction at end of life
- Patients and families have better understanding of their prognosis and have developed an end of life plan
- Staff feel more comfortable initiated difficult conversations

References:
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