End of Life Education Quality Improvement Project – Somerset NHS Foundation Trust

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End of Life Care Education Team

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Project Summary:

The End of Life Care Education team devised a project involving 3 wards across Musgrove Park Hospital to consider approaches to the effective rollout and maintenance of end of life care education for staff. They also simultaneously carried out a small audit of end of life care on these wards in order to ascertain how and if national standards for end of life care are being met.

The project results suggest that there are levels of poor compliance with domains related to NICE Quality Standards at the end of life in most areas. However, mandatory education does not seem to be the answer to remedying this; attrition levels to such courses are too high and conclusive evidence as to the courses' effectiveness have not been explicitly found.

However, targeted short teaching sessions based on the ward were found to be both popular and impactful with improving staff confidence around end of life care topics. 'Trolley teaching' proved to be a simple and quick method to bring small amounts of education and crucially signposting to other education and resources options to busy staff. It would be the recommendation of this team that this method of education is employed more widely across the Trust, to increase not only education but also the presence of end of life care resources and support to staff. The results for the trolley teaching are encouraging and further development of this service would be beneficial to fully understand if the significant cost implications of this running trust wide would be impactful.

This project showed that the individualised end of life care plan is currently being under used; 2024 will see the development of a new care plan for the whole Trust, enshrined in national end of life care guidance, and it is therefore the recommendation of this team that the roll out of this tool has a well-planned, all-encompassing and thorough education structure around it. A renewal of enthusiasm and engagement of the care plan will help drive forward important key standards around palliative and end of life care, therefore improving the care given overall.

Background:

In the 2022 CQC report for Somerset Foundation Trust (SFT) there was a recommendation that "the Trust should consider making End of life Care training mandatory for teams that are likely to deliver this care" (appendix A). This task was highlighted to the End of Life Programme Board and End of Life Care (EOLC) Education Team as an area for improvement. Following discussions with both the EOL Programme Board and the Learning and Development department at Somerset NHS Foundation Trust, the EOLC Education team felt that a quality improvement (QI) project would be required. This would demonstrate how best to deliver end of life care education in terms of feasibility of delivery, change impact for patients, relatives, and staff, as well as sustainability for future practice.

Underpinning all the care given to patients at the end of their life at SFT are National Institute for Care and Excellence (NICE) Guidelines, in particular NG31 (Care of Dying Adults in the Last Days of Life), QS13 (End of Life Care for Adults) and QS 144 (Care of Dying Adults in the Last Days of Life). All of these quality standards and guidelines clearly state important actions in the planning and delivery of care for dying patients such as: recognition of dying, communication, anticipatory prescribing, individualised care, advance care planning, hydration, and support for carers. The current delivery of care for dying patients utilises these quality measures but one important factor highlighted within the Ambitions for Palliative and End of Life Care publication, is the incorporation of education and training to meet these quality standards.

The current delivery of end of life care education at Somerset Foundation Trust is as follows: the Supportive and Palliative care teams at both the Musgrove (MPH) and Yeovil (YDH) hospital sites deliver training that is designed for registered nurses. YDH hold a study day for Health Care Assistants (HCAs). The MPH course "Ambassadors in Palliative Care" is a 3-day course that covers a broad range of topics from symptom management to ethics and the care to be delivered at the end of life, this course is run twice a year. The YDH course is 1 day and focuses around the 5 principles of care (Leadership Alliance for the care of dying people 2014) and the key areas of the Individualised End of Life Care plan, this is delivered every other month by the YDH specialist nurses. The End of Life Care Education team deliver a course on a monthly basis designed for all staff within SFT (as well as other Health and Social Care organisations countywide) called 'Communication in End of Life Care' that has been delivered to approximately 275 members of staff over the course of 16 months (at the point of writing this report). The Somerset FT clinical skills team deliver teaching sessions about the use of syringe drivers, and St Margaret's hospice also run and deliver a range of courses on palliative care topics that are available for any member of staff working within the catchment area to book onto (a £10 booking fee is required for these sessions).

One specific topic of teaching that is undertaken by the EOLC education team is Treatment Escalation Planning (TEP). It is important to note that all of the courses run by the team include a session that looks at TEP, but there are additional e-learning and face to face modules available to all staff about aspects of treatment escalation planning. TEP is not exclusively an end of life care issue as the aspects of it should

be reflected for all patients in the care of SFT, however there are some highly important aspects of the palliative stages of a person's life that can be impacted significantly by TEP.

It should be of note that whilst the two other hospices within the network offer education programmes, St Margaret's Hospice Care has been specifically mentioned above as this hospice is within a mile of Musgrove Park Hospital in Taunton, where the participating wards are based. It would be unlikely that staff would need to access learning from Weston Hospice Care or Dorothy House Hospice Care due to the geographical location.

As part of this project the End of Life Care Education Team undertook the Trust Silver QI training; this enabled the team to gain guidance, support and mentorship for this project as well as developing their own personal skills around this area. The Silver QI training also supported the EOLC education team with important stages of planning the project; forming the team, ensuring that important stake holder members were included, and the project goals and aims were set clearly and were achievable. Key members of the team included contacts from clinical areas such as ward leaders and admin staff, as well as the EOLC Education, the Supportive and Palliative care teamed based at MPH, and a member of the SFT learning and development team.

In order to ensure that patients at the end of life were receiving the best possible care, as per the NICE guidelines and Quality Standards, CQC stated that this could be supported by embedding appropriate EOLC education for all staff. However, the question of 'how' to best achieve a sustainable and impactful education plan became the aim of the EOLC education team.

There were a number of key aims set out by the project team. These included:

- To understand if end of life care education should be made mandatory.
- To increase end of life care education for ward-based clinical staff on Eliot Ward at MPH from zero hours to 2 hours per staff member by Feb 2024.
- To improve the confidence, knowledge and skills of ward based staff when caring for patients at the end of their life.
- To improve the care given to patients at the end of their life

It should be viewed that the improvement of staff confidence allows individuals to effectively care for patients who are dying and support their families successfully, thus reducing errors, complaints or other issues that may impact the patient and family's experience at a challenging time. Whilst it is acknowledged that this QI project was likely too short in duration and too small in scope to fully explore the complex and multifactorial impact of healthcare education on changes in practice (Smith et al 2019), our team still felt it relevant to take the opportunity

to look more closely at clinical care during this time frame, to help identify trends and areas of concern for ongoing education. Furthermore, the team were also interested in clinical outcomes for patients and whether improving confidence levels in staff had a direct impact on improvements to patient end of life care, and whether any data could be captured to reflect this.

The broad ambition of the scope of the project was streamlined into a specific problem statement by the EOLC Education team which in turn helped to form a measurable and specific aim:

To improve care experience, we will increase the number of ward based clinical staff self-assessing their knowledge and confidence in caring for those at the end of life as 'good' or above on Eliot ward by 15 from 5 to 20 by 31/10/23.

Collectively these aims will support the team and wider network to understand how education can be best directed for maximum positive impact and outcomes. This will allow the team to understand where best to allocate resources for success, meeting the goals of the CQC and SFT vision for the development of end of life care delivery.

Outcome measures:

- Pre and post project audits of medical notes of patients who died on each ward in a specific timescale – review of the medical notes.
- Self-reported feedback from staff via MS forms about the teaching methods/content/their confidence.
- Discussions and evidence gathering from bereavement team about family experiences.
- Discussion with PALs/complaints team about any feedback from identified wards re: end of life care.

Audit methods:

A baseline audit was conducted on all three of the participating wards prior to starting the education roll out, this work was supported by the SFT audit team. The focus of the audit questions surrounded the diagnosis of dying, whether this was communicated to the patient and their family, whether hydration and nutrition was discussed, whether just in case medications were prescribed and aspects of the treatment escalation plan. The details of the questions asked can be found in the appendix B. These themes were highlighted and chosen from previous audits that the trust undertakes such as NACEL (national) and Treatment Escalation Plan (internal), as well as common themes from end of life care research and analysis.

The EOLC education team reviewed the notes of a number of patients following their death on each ward, several of these notes were rejected as the patient was not expected to die and therefore the care they received was not classed as "end of life." A total of 8 sets of notes (or data points) was used from each clinical area for the audit. For the baseline audit the deaths were selected that occurred leading up to (and

including) the 17th of July 2023, in some cases this meant that there were patients who had died 3 months before this date as some of the wards did not have as many deaths as others.

There was initially a midpoint audit planned for this project, however this was cancelled following the initial audit as it became clear that the number of patients who had died in each clinical setting during that period of time would not give sufficient evidence to effectively reflect the work that was occurring. Overall, the number of deaths per ward during this project time frame was lower than hypothesised, leading to a smaller amount of data collected by the team.

The final audit stage was completed once all the teaching was finished, and there was "cooling off" period of at least 4 weeks to give time for the education that had been delivered to be imbedded into practice. The deaths of patients from each of the wards was selected for the period between 17th July 2023 and 6th November 2023, again 8 adult patients receiving end of life care were selected from each ward area giving a total of 24 deaths. A number of the deaths were also excluded from this list due to the fact that the patient had died unexpectedly and therefore was not receiving end of life care.

Methodology:

Three wards within Musgrove Park Hospital self-selected following a request for interest through the Somerset FT communications team (published 3rd April 2023 Appendix C) and on X (formally Twitter) (Appendix D) Dunkery (stroke), Eliot (dementia and acute medicine) and Beacon (oncology) wards volunteered to be part of the project. Each ward was randomly allocated by the EOLC education team in to being the "control ward," "complimentary ward" or the "mandatory ward" and plans were made for the education delivery for each of the ward settings.

The EOLC education team contacted each of the wards in a letter sent via email (Appendix E) to inform them of which allocation they had received and to make plans for the future delivery of teaching. The wards identified individuals to act as a contact link between the education team and the ward, this enabled the ease of communication and dissemination of information, the education team met with this link staff members to discuss the upcoming project and to ensure that if there were questions or any support that was needed it was answered.

Dunkery ward was allocated as the control ward; the team conducted clinical audits at the same time as the other clinical settings. Focusing on deaths on the wards up to the 31st of July 2023. Dunkery ward also had a display board set up which contained information and signposting about the end of life education available to staff. Dunkery ward staff were given access to further training methods outside of the initial

project time, this was to ensure that there was parity across all of the clinical settings as part of the project. The outcomes of this teaching will be discussed later.

Beacon ward was allocated as the complementary ward; we conducted clinical audits of the deaths that occurred up to the same dates as Dunkery. Beacon ward also had an information board set up to inform staff of the education available. In addition to this the staff received "trolley teaching" – this was a quick teaching technique that aimed to deliver 5-10 minutes on a range of end of life topics that are relevant to clinical staff.

Eliot ward was allocated as the mandatory ward; as part of the education delivery a 2 hour mandatory teaching session was devised and delivered to staff. Staff were allocated to time slots where they were expected to attend this teaching session. The teaching session covered a broad range of end of life topics (communication, TEP, normal dying, symptom management, syringe drivers, care after death, use of appropriate language and documentation). Eliot ward also had the audit conducted for the same date period, as well as the delivery of trolley teaching as identified above.

	Dunkery	**Beacon**	**Eliot**
Education board			
Trolley Teaching			
Mandatory teaching			

Following the delivery of education to the ward areas (31st July 2023 – 4th September 2023) there was a cooling off period until the commencement of a second phase of auditing on 6th November 2023.

Methods for delivery of education:

There are many theories about how adults learn, and being mindful and inclusive of this was highly important to the EOLC education team when planning the delivery of teaching. Furthermore, it is important to consider impactful ways to retain learning, as well as the delivery of the education itself, as research shows that learners tend to lose between a quarter and half of their acquired knowledge within a year (Lindsey et al 2014).

The team considered Learning Retention theory's three stages of learning in order to try and increase the longevity of the knowledge acquired. These stages are acquisition, consolidation and tuning (Kim et al 2013), acquiring the knowledge, consolidating in context of the situation and fine tuning it to the environment.

The team therefore aimed to combine retention theory with accessibility and feasibility when choosing educational activities for engagement with busy ward staff. All wards were given access to information to explore independently through promotion of the Somerset End of Life Care website; this foundation was then built on through more formal classroom based learning and short interactive teaching sessions on the ward in order to help consolidate and modify the knowledge acquired in an attempt to improve retention.
With all of these factors in mind, a variety of methods of delivery of end of life education were considered by the team, and as the result of this the following activities were decided upon for the project.

Educational notice boards:
Each ward was asked to allocate a display board within the clinical setting to advertise to staff the range of end of life care teaching that is available to them. The boards were either in the staff room areas or in the ward treatment room, the content of the boards was designed for staff only and not for patients or relatives. If the information was for patients and relatives too, the contents would require discussion and approval from the trust to ensure plain English was used, as this project was designed for staff and surrounded staff education this process was not necessary. The board contents were populated by 2 members of the team (AG & LJ) and had identical information for each setting. The contents included: website poster, QR code directing to the website, a Somerset Planning Ahead for your future health and care brochure, bereavement cards, bunting, newsletter, upcoming courses poster.

Trolley teaching:
This teaching style was designed to enable the delivery of quick education sessions within the clinical setting. This was delivered only to Beacon ward and Eliot ward as they were the complimentary and mandatory wards.

The team created a file of resources and guidance for the educator who was delivering the teaching. The teaching guidance structure was created to give a clear plan/outcome to the teaching session without providing a script that needed to be followed, this was felt to be beneficial if multiple different people were allocated to teach sessions; therefore, allowing each individual to deliver the session in their own way whilst ensuring that the learning objectives were the same.

The teaching topics were based around NICE guidelines NG31, QS13 and QS144 as well as trust identified topics that are the focus of the individualised end of life care plan. There were 14 topics within the resource folder that had the guidance and additional training resources to support them they were:

- Pain
- Breathlessness
- Agitation
- (Somerset) Treatment Escalation Plan (STEP)
- Nausea and vomiting
- Communication
- Secretions
- Individualised end of life care plan (IEOLCP)
- Nutrition and hydration
- Skin care
- Continence
- Mouthcare
- Spiritual care
- Constipation

The design of the trolley teaching was to attend the wards (Beacon and Eliot) twice a week with the resource trolley, capture whichever staff members were available on the ward at the time, then deliver 5-10 minutes of teaching on one of the topics. Once the teaching was completed staff members were able to carry on with their shift. Participants were also given a free Somerset End of Life and Bereavement Care website pen, as well as sweets as a way of thanking them for their attention during the teaching.

The educators were allocated to each scheduled session prior to this aspect of the teaching being commenced; this was done by KP (appendix F). As well as the EOLC education team, this aspect was also supported by the Musgrove Specialist Palliative Care Team (SPCT) giving up to date clinical expertise. The topics chosen were based around the expertise of those delivering the teaching session, e.g., a nurse to deliver the session around pain, the treatment escalation plan lead to deliver the TEP session. The times selected for each session were dependent upon the availability of the teachers, as well as what would work best for the ward areas - advice for this was sought from the ward managers who suggested that afternoon teaching could be most effective to avoid lunch breaks and other ward based activities such as drug rounds,

board rounds or meal times; therefore ideally enabling as many members of staff to be available to attend sessions as possible. However, as the project progressed, late morning was actually found to be a better time to attract more staff to the sessions.

Of the 14 teaching topics that were available, the EOLC Education team identified certain key areas to focus on which were reflective of PALs concerns/complaints or through feedback from other teaching sessions. The chosen topics were pain, agitation, mouthcare, communication, TEP and the individualised end of life care plan (IEOLCP).

Evaluations of this teaching methods were chosen to be simple and quick – RAG (red, amber, green) coloured magnetic smiley faces were purchased, and participating staff were asked how they felt about the chosen topic prior to teaching, placing an appropriately coloured face on a board (Appendix G). Following the teaching the students were asked to rate their feelings about the topic now that they had received some teaching about the topic (with the view that there should be an improvement of their feelings). An evaluation form was produced to gain more detailed feedback for the teaching session, but it was poorly filled in, mostly due to staff's time pressures but also, staff members frequently did not have their personal phones in their pockets to scan the QR code that linked to the MS form. On reflection of this a printed form could have helped to collect an appropriate volume of data to give an accurate reflection of the impact of this type of teaching.

Occasionally participants were pulled away from the teaching to conduct clinical duties and therefore did not receive the full teaching delivery. This was an understandable risk due to the nature of this type of teaching; patient care is always prioritised over education when in a clinical environment.

Mandatory teaching:
For staff on Eliot ward, a two hour teaching session was devised. Titled "Introduction to Palliative Care". The session was designed to give an overview of the important factors that are required in the acute setting for the delivery of palliative and end of life care. The learning outcomes were as follows:

- Develop knowledge of the use of appropriate language in relation to palliative and end of life care
- Understand the importance of good communication in end of life care
- Discuss the importance of treatment escalation plans and how they can impact a patient's care
- Recognise the changes that someone may experience in the "normal dying" phase of life
- Understand the significance of good symptom management, and the use of "just in case" medications to do this. And when syringe driver use is appropriate for the dying patient.

- Recognise and understand the use of the Individualised End of Life Care Plan in the acute setting.
- Develop an understanding of the importance of caring for the patient after death, including the importance of maintaining their dignity during this time.
- Understand the importance to clear documentation throughout the care of the dying person.

Devised from a number of teaching sessions that the EOLC Education team already produce and regularly deliver this teaching session was fairly straightforward to write and put together. The teaching was 2 hours long, the first hour focused on topics such as definitions of palliative care versus end of life care, communication, use of appropriate language and breaking bad news using the SPIKEs model. For the second hour, it was a more clinical focus, where the participants were taught about identification of dying, and what happens to the human body as it deteriorates and dies, symptom management at the end of life including the drugs used for the treatment of these symptoms, syringe drivers, spiritual care, and care of the person after death.

The allocation of attendance for the mandatory teaching session was done by the EOLC education team (appendix H) and did not reflect the working patterns of the ward staff, if staff were not able to attend, they were informed that they should contact the team to rearrange the session. Teaching rooms were booked at MPH academy, where there was a potential of four members of staff allocated to each session. It was designed that there would only be a few members of the team taken off the ward at once to maintain safe staffing ratios, so the bookings were made with three staff members booked into each slot. If this were to be the chosen method of delivery to be taken forward, a different system of booking and allocation would need to be considered; allowing staff members to autonomously book their teaching slot that fitted in with their work schedule and personal lives.

Eliot ward staff were sent a letter (Appendix I) to inform them of when they would be expected to attend teaching, that they would receive their hours back in lieu of attendance should they attend in their own time, which was agreed with the ward manager, and that if they were not able to attend the teaching then they should rearrange it by contacting the EOLC education team. Also within this letter was the information that this was mandatory teaching and attendance should be considered in the same way as basic life support training or other mandatory teaching as defined by the trust. In allocation of the teaching sessions the EOLC education team attempted to mix the professionals to have both qualified and unqualified staff in attendance of all the sessions.

There was an open invitation to other members of staff (AHPs, volunteers, etc.) that work on Eliot ward to attend the teaching sessions – this was advertised on the information board, however there was no additional uptake of this offer. This was the only difference in the content advertised on the Dunkery and Beacon information boards.

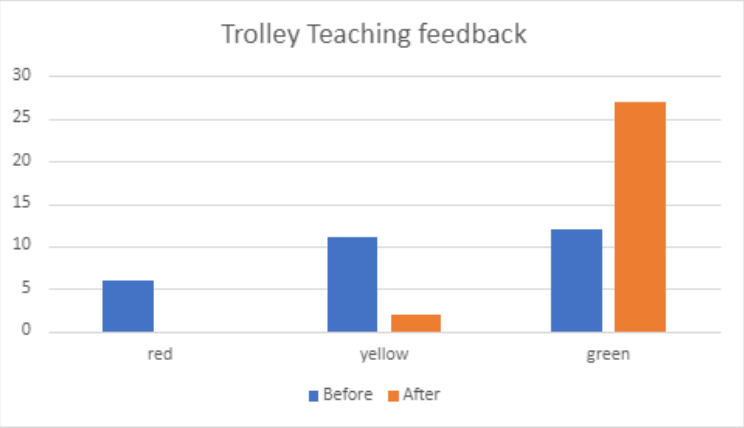
Timings of the teaching sessions were 09:00-11:00, 11:30-13:30, 12:00-14:00 or 14:30-16:30. Non-attendance was highlighted to the ward leader by email, and they were encouraged to ensure staff were aware of the teaching, able to attend the teaching, and the importance of the session was cascaded down. These emails were sent on two occasions in the 6-week period of teaching delivery, and a small number of staff rearranged their missed sessions to join the team on an alternative slot.

Evaluations for this teaching session were done via an MS form which was available to scan for staff attending at the end of the teaching session, the final slide of the presentation featured at QR code that would link to the evaluation. This evaluation included questions about confidence and knowledge of the subjects included, as well as practical questions about the timings of the day for attendance, feasibility of attending during a workday etc. Due to the time pressures (2 hours) it was not felt necessary to ask attendees to complete a pre-course evaluation as in some other teaching sessions. However, this type of pre and post course evaluation could give a more identifiable or accurate demonstration of a potential rise in confidence and knowledge.

Feedback and Evaluations on training – Trolley Teaching

Trolley teaching was delivered to Beacon Ward and Eliot Ward on 8 occasions – fewer occasions on Eliot ward occurred due to the ward closure for COVID/infection prevention reasons. During this time a total of 27 people attended the teaching on a range of topics: pain, IEOLCP, agitation, mouthcare, both communication and TEP were taught twice. The range of professionals attending the teaching was broad, although the majority of attendees were registered nurses and health care assistants a number of other professionals including junior doctors, therapy staff (therapy assistants, physios and OTs) and radiographers attended.

As previously explained the participants were asked to rate their feelings in a simple pictorial way using the smiley faces to answer the questions "how do you feel about *TOPIC* before you have teaching" if not confident or not happy then they were advised to place a red face on the board, if indifferent or mediocre a yellow face, and if good or confident a green face. As a team we felt it important that even if people rated themselves as green, we asked them to remain and listen to the teaching as there may have been aspects of the teaching that would be of use to them. Once the teaching was complete the participants were asked the question "how do you feel about *TOPIC* after you have had teaching?" and they were asked to rate their feelings/confidence in the same way as before. The graph below shows the results:



	Red	Yellow	Green
Before	6	11	12
After	0	2	27

It is clear from the data that staff rated themselves better following the teaching session that they had. 80% of staff felt that the trolley teaching enhanced their knowledge and skills set, giving them clinical confidence pertaining the 6 chosen topics, the remaining 20% rated themselves in the green category prior to starting the teaching session. This result could therefore be extrapolated to suggest that there would be such a rise in knowledge, skills, and confidence for all of the 14 topics that the trolley teaching would aim to cover in the future.

Other points of note, although there were only three responses to the formal evaluation through MS forms the staff that completed it gave positive feedback, reporting that they felt that the teaching was effective and enjoyable. Other anecdotal feedback from ward-based staff in real time was very positive; a lot of participants reported how helpful and simple the idea was. There was also a positive response for more senior staff (ward leaders and consultants) about the delivery of education, and verbal encouragement that this type of teaching could be beneficial in other clinical areas.

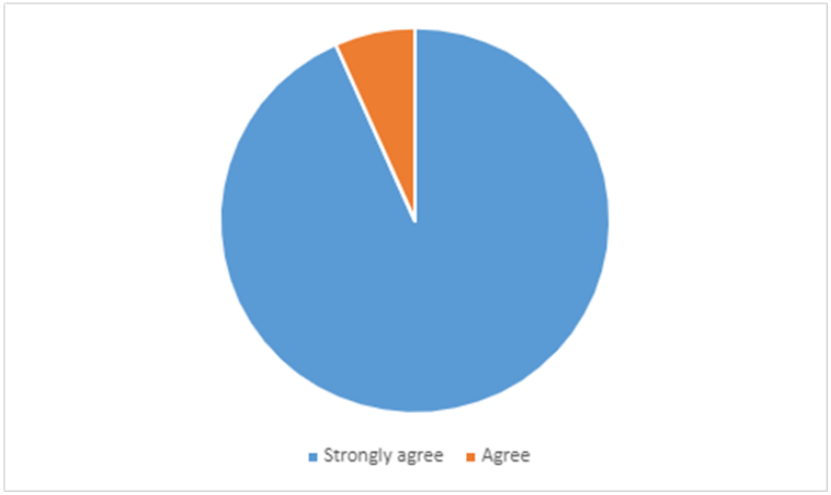
Due to the nature of regular contact with the chosen wards it enabled the team to develop a rapport with staff, and regularly the ward staff were able to recommend to colleagues to listen to the presentations. This was felt to be a positive aspect by the education team and was encouraging for the establishment and imbedding of the teaching process – it gives a suggestion that conducting this teaching on a regular basis would have a positive impact on the wards that received this method of teaching.

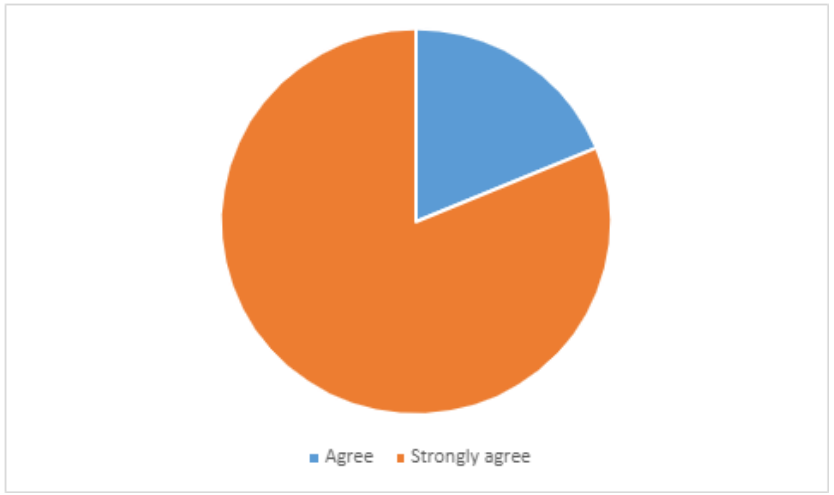
Feedback and Evaluations on training – Mandatory Teaching Session

There was a total of 19 employees from Eliot ward that attended the mandatory teaching session. This was a 2-hour lecture type teaching session as previously described, it did also include activities, space for questions, group discussion and interactions, sharing of experience was actively encouraged as it would offer time and space to discuss clinical situations that may have been of benefit to individuals as well as their colleagues.

The majority of the feedback form questions were designed on Likert scale, asking if participants strongly agree, agree, neutral, disagree or strongly disagree with the statement asked. 15 of the 19 participants responded to the questionnaire. In the completion of the feedback participants were encouraged also to give as honest feedback as they could; it was highlighted to the participants to consider that as this was part of a project it was important for the EOLC education team to understand truly how the attendees felt. This would heavily inform developments within the future planning of this type of teaching in particular whether the course would be suited to be delivered via Teams, as a webinar/e-learning or whether face to face was the most appropriate option.

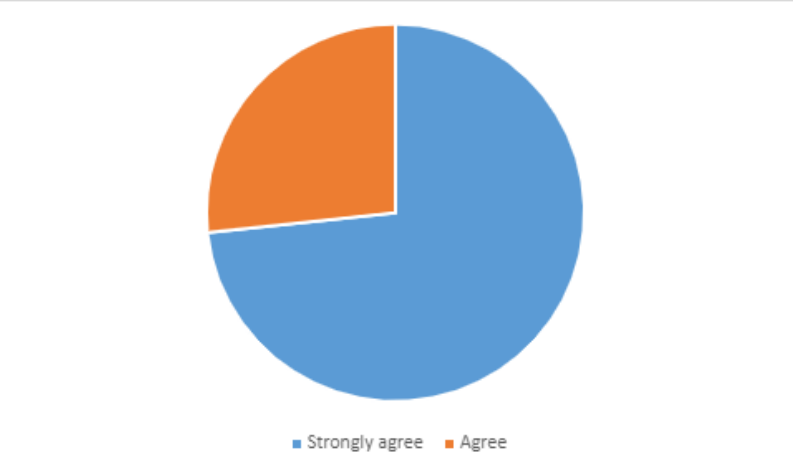
Some key aspects of the feedback of the mandatory teaching sessions were:





When asking individuals if their knowledge of end of life care had increased and if their confidence had increased following the teaching session 100% of participants agreed with the statements. 14/15 strongly agreeing with an increase in their knowledge and 13/15 strongly

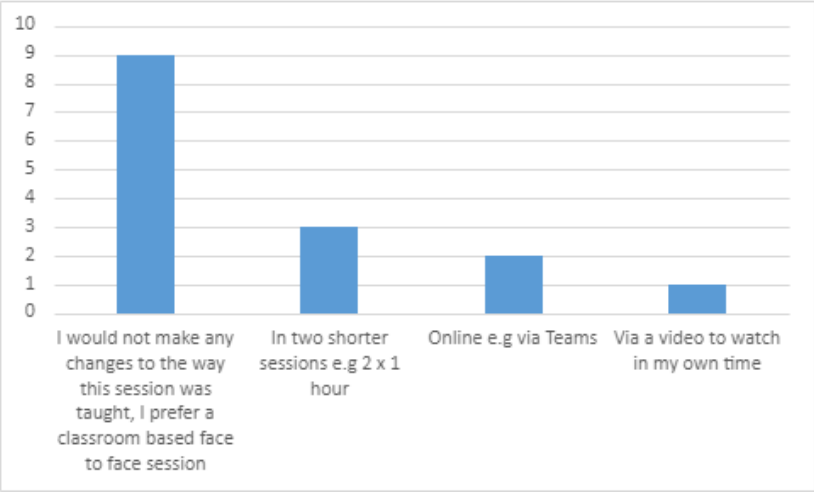
agreeing that their confidence had increased following the teaching session. Thus, showing that as a project this type of education was meeting the aims that it had set out to, giving extremely strong evidence for the need to invest in the design of further development of an end of life care introductory programme for all clinical staff.



All staff members (answering strongly agree or agree) felt that the allocated 2 hours was enough time to gain an "Introduction of End of Life care." This came from a mix of staff grades, which was highly important for informing whether the course had been pitched well to both registered nurses as well as health care assistants. It was important to understand and deliver education based on the needs of the participants regardless of their banding. This can also inform planning for the development of courses in the future.

13 of the 15 members of staff felt that the face to face delivery was "excellent" and the remaining 2 (13%) people felt that the delivery was "very good." This question was followed up with one about preferring a different delivery style; the majority of staff feeling that classroom-based education should be the preferred method.

However, it is important to note that the preference for other forms of education delivery is key for further development of this education programme; a mixed method could be utilised to support a great number of staff members. This is an important consideration when planning future training, and the larger scale roll out for this project.



What is another important consideration is that if an e-learning (or other delivery methods) module was developed and utilised how the level of engagement and learning from this would be assessed – when something as clinically important as end of life care is the topic of the teaching, is e-learning enough deliver what is required for effective care?

When questioned about whether staff felt that all of the necessary topics were covered within the 2 hour time slot, all staff reported that they agreed with this; 11 of whom strongly agreeing. Following on from this question there was scope to answer freely about what other content could be included within it and 2 people answered – one requesting "assistance and care of the patient's loved ones" and another suggesting that "how to communicate with relatives" would be valuable, also that the use of role play could be of value.

Both of these suggestions are important as the anecdotal feedback and discussions that occur as part of other teaching sessions are usually centred around professionals' experiences and fears of talking to patient's families, and the challenges that this presents. This could also provide a valuable flag for educators to signpost to other courses that are available to support members of staff with these aspects of end of life care.

As a final question for the evaluation, it is common practice for the EOLC education team to ask for a response to the following statement: "As the result of attending this course I will now..."

- I will care more and take note of all that is needed to be done for someone coming to the end of their lives.
- Feel more confident with caring for EOL and palliative patients.
- Able to care my EOL patient in an appropriate way.
- Take all information learnt and apply to my practice.

- Very confident dealing with Palliative care patients and their family
- Be more equipped the additional more information learned.
- I understand more between palliative care and end of life care.
- Be better at EOL care.

Although not in a quantifiable form, these statements are hugely valuable to demonstrate the impact of the attendance of this teaching session. There are key themes within these answers about confidence and learning, being more equipped to care for patients at the end of their life that are essential for answering some of the targeted aims of this project. As well as answering the project aims it also gives a clear demonstration of the positive impact that this 2 hour teaching session has had on the staff attending.

Reflections on the delivery of education:

Attendance of the mandatory teaching session was poor (around 40%), this could be as the result of a number of factors such as ward pressures, staffing issues, lack of knowledge of the course and its importance, personal sickness. Discussion held via email with the learning and development team to compare this result to other trust wide mandatory teaching sessions. This in fact showed similar numbers of nonattendance for key topics.

Session timing for first mandatory teaching session in the day was 09:00 and a number of members of staff did not attend the training at this time specifically; this could be altered to ensure that those doing shifts were able to attend, or those dropping children at school could arrive in time for teaching. Although when questioned about this factor in the post course evaluation all of the participants felt that the time slot was appropriate and did not raise any concerns with it. Therefore, a variety of start times and teaching sessions may be the most appropriate way to plan any future roll out of this programme.

Trolley teaching required staff to be available at the time when the education team attended the wards. When the teaching team went to the wards it was often that staff were tied up clinically, or not available due to break timings. The nature of this teaching was that the staff available would get teaching, but this could have potentially excluded a number of staff members, including night shift staff due to the scheduling of the teaching delivery. Subsequent attempts to deliver this type of teaching on Dunkery ward have gleamed greater numbers of staff availability between 10:00 and 11:00 rather than later in the day or closer to mealtimes, or drug round times.

On a number of occasions attendance to deliver teaching to Eliot ward was not possible due to ward closure – there was a period of two weeks during the education delivery time where one or more bays on the ward were closed to the COVID outbreak. Thus, meaning that it

was not safe for the EOLC education team to attend the ward and teach the staff –this also utilised a lot of time for the EOLC Education team who are not based on site to prepare for the session which could not go ahead. If this model of education delivery was to be scaled up to cover the whole trust the planning process for this could be altered; for example, if there were five wards to attend and one ward is closed or inaccessible then there would be four further opportunities to deliver education, therefore making this more cost and time effective.

Chosen days for the delivery of teaching were based upon the EOLC education team's working days (the team consists of 5 part-time staff), and not fully reflective of the needs of the services or allowing for much flexibility in the delivery. If this was to be expanded there could be a required expectation of a service delivery by more than just the EOLC education team; working in combination with the SPCT members on both sites a programme of trolley teaching could be established and delivered on a rolling programme (weekly, 2 weekly or monthly potentially). Consideration would need to be made for how this could be delivered to community hospitals if deemed successful and of benefit to staff. There would need to be a consideration for the face to face delivery of any mandatory education for both YDH and MPH sites, as well as how to deliver this to the community hospitals.

The use of notice boards for educational updates is a widespread practice, a consideration should be made if a whole board dedicated to end of life care is necessary or could be incorporated within existing education boards present in ward areas. It should also be of note that to remain current and effective the content of these boards would need regular updates, perhaps on a monthly basis to ensure that staff remain engaged with the topic and there is the opportunity for regular learning. Assurance of this continuity would require a member of staff (whether that is the EOLC education team or the SPC teams on both sites) to create teaching materials, and disseminate the information, a role that has yet to be discussed with the team members and agreed upon.

Audit outcomes

One of the main aims of this project was to discover areas of end of life care where education and support is needed to help improve clinical outcomes for patients who were dying in the acute hospital. This was done through an audit of clinical pre and post the education delivery period. This looked at notes from each of the 3 wards areas and analysed the deaths of these patients against the quality standards that have been identified in appendix B. It should be of note that the number of expected patient deaths across the audit period was low for these ward areas, a number of patients were excluded from the audit because although they had died on the wards under scrutiny, they were patients who were not expected to die and were not receiving end of life care.

As a general rule, whilst the standards of care are different on all of the ward areas, Beacon ward tended to have better results of the audits than Dunkery or Eliot ward. This could be as the result of a number of factors such as speciality culture (oncology being the historic basis for

the foundation of the modern hospice movement) which could have led to there being better, more inclusive conversations around death. It could also be ward culture, where staff are more prepared to discuss these aspects of caring for dying patients; this was one factor that was highlighted by staff on the ward when the team attended to do trolley teaching, many of the pre-teaching responses were green and staff reported feeling confident about the topics chosen. There could also be an aspect of staff experience, staffing levels, or turnover of team members that changes culture or confidence amongst those working on the wards; for example if there are few members of staff present who have experience in caring for dying patients or having challenging conversations there will be fewer opportunities for their colleagues to learn from, to be mentored by, or to act as role models for the type of care that is necessary. Staff confidence has been one of the biggest priorities of the EOLC education team within this project, to the point where although the clinical audit data may be limited in its outcomes the impact of the education on the staff themselves could be considered to have a higher reflection of success.

The audit (Appendix J) demonstrates the level of ward compliance with NICE QS 144 and demonstrates the areas for concern, but it is important to note that the samples sizes are fairly small and as such it is difficult to determine if changes are directly influenced by increased education input, or lack of. However, it clearly underlines that there are some areas where compliance is very minimal and as such action definitely is needed to remedy change from an education point of view.

There are areas for improvement across the audit data. There are several standards linked to communication with the patient around their end of life care, and the fact that they are dying that are consistently poorly reported. The standards around hydration and nutrition are not met across all 3 wards. Mental capacity is rarely recorded on the TEP forms and there is often little detail to personalise the TEP form, e.g., 'what matters to me'. Overall, there are a number of domains where we can celebrate best practice, such as recognition of the patient approaching the end of life, which is generally well documented by the wards. JIC meds are being used regularly in the majority of cases. The wards are overall communicating to families that their loved one is dying. TEP resuscitation decisions were documented on all occasions, and escalation decisions are mostly documented too.

Overall, there is also plenty of scope to support wards to develop targeted improvements to certain standards. The duration and sample size of this audit is probably insufficient to note any direct impactful change of an education programme, but it gives an overall sense of the areas of concern to target future education.

Key areas for improvement include support for staff to help them with communication with the patient at the end of life, to help them to understand more about their emotional, spiritual, nutrition and hydration needs. Individualised end of life care plans should be utilised more; but there are works already in progress to unify this care plan trust wide, alongside this an education plan would be embedded to promote

best practice would be beneficial. Treatment Escalations Plans need to be universally improved and there is already a strategy under the ICB to address this as it is a well-known issue across the Trust.

In order to ascertain if there had been any improvement to individual compliance rates across the wards pre and post education delivery, the team also compared compliance percentages across the two audit periods. The table below shows how there have been some small improvements to compliance rates, even though compliance still wasn't fully achieved. This is encouraging, as it shows that in some areas, such as care planning and TEP discussions, there were some small improvements to the wards that received trolley and mandatory education, although it is still difficult to say with absolute certainty that improved education was the reason for this.

Improvements in compliance

Worsened compliance	No change	Improvement

		Control	Complimentary	Mandatory
1	Is there evidence in the patient record that it was recognised by the MDT that the patient is in the last days of life?			
2	Is there evidence in the patient record that there was a discussion with the patient that the patient is approaching the last days of life?			
3	Is there evidence in the patient record that there was a discussion with the patient's family that the patient is approaching the last days of life?			
4	Does the patient have a LDL care plan?			
5	Is anticipatory medication prescribed for the patient in LDL?			
6	Is there evidence that the patient's spiritual/emotional health needs were discussed with the patient in last days of life?			
7	Has hydration/nutrition been discussed with the patient in the last days of life?			
8	Has hydration/nutrition been discussed with the patient's family in the last days of life?			
9	Has a STEP form been completed for the patient?			
10	Was the STEP form completed within 12 hours of admission?			
11	Is there documented evidence that the STEP was discussed with the patient?			
12	Is there a resuscitation decision?			
13	Is there a documented escalation treatment decision made?			
14	Was a capacity option made?			
15	Is the 'What is important to me' box completed?			

16	If 'consider hospital transfer' or 'may be for life prolonging treatment' is ticked, is there a documented rationale in the 'what is important to me' box?			

Some of the themes that all of the ward areas struggled with was in relation to discussions with the patient and their family about an approaching death. This is a common theme across previous audits, and is widely talked of areas where professionals struggle. It could also be seen as a suggestion that the education was targeted at the wrong groups of professionals – the ward nurses and healthcare assistants would not be expected to deliver this news to patients, or their families and the role would fall to the doctors on the wards; suggesting that there could be scope for improved education to more senior colleagues to improve these standards.

Another area of improvement for both the complimentary ward and the mandatory ward was around the discussion of nutrition and hydration for dying patient's families. Eliot ward showed improvements from 11% before to 50% after for both nutrition and hydration, Beacon ward showed a small improvement from 14% to 22% with discussions about hydration and 14% to 33% for nutrition. These were aspects that were taught as part of the mandatory sessions and when discussing the IEOLCP within trolley teaching, highlighting the importance that we do not starve patients at the end of their life, rather offering something they would enjoy eating or drinking in a safe capacity. For Dunkery ward this importance was not formally taught to staff, and the results of the audit showed a decline from 33% of families having the discussion about hydration and nutrition to 0%. It is unclear if this is result would hold statistical significance, however it is important to note the impact of positive changes to the areas that have received education.

Some of the standards focus on aspects of the Treatment Escalation Plan. The data that has been collected demonstrates that there are some challenges around the completion of the current TEP form, particularly around the documentation of "what is important to me", and around whether the patient should be considered for hospital transfer. The second of these standards may not be being met as it is felt that the patient is dying in hospital and therefore does not need this to be considered. However, the aspects of decision making around what a patient's wishes would be and what is important to them are crucial for providing appropriate care to the individual. There are positive aspects of TEP side of the audit, when reflecting on whether the clinical decisions were discussed with the patient and in all ward cases there was an improvement.

One important aspect of the audit and project process was that there was occasionally a discrepancy between the participants that were taught, and the professionals that were completing the IEOLCP and TEP. When assessing the standards of the audit it focused on discussions with patients and their relatives, commencement, and completion of the IEOLCP, accurate completion of the STEP form and other such activities; in the acute setting it is important to remember that these activities are primarily conducted by the doctors, who did not engage with this project. Conclusions made about the impact of the education may not be truly reflected in the audit outcomes due to this disparity.

Objectives *(Describe the project objectives and desired outcome (QI aim statement).)*

To improve care experience we will increase the number of ward based clinical staff self-assessing their knowledge and confidence in caring for those at the end of life as 'good' or above on Eliot ward by 15 from 5 to 20 by 31/10/23

Key Changes *(Describe the key changes, the work undertaken to deliver each change, and whether this has been Fully, Partly or Not Met.)*

Change Idea or Key Objective or Key Deliverables 	**Work Undertaken to deliver the Change Idea or Key Objective**	**Fully / Partly / Not Met**
2 hour mandatory teaching session	As above	Fully met
Trolley teaching	As above	Fully met
Education boards	As above	Fully met
Ward meetings	Time critical, unable to release staff to attend.	Not met

Project Benefits and Measures *(Describe the benefits/measures against the quadruple aim. Refer to the benefits as identified on the Pups and measure of benefits plan)*

Improved Outcomes/Health outcomes	**Colleague Satisfaction**
Patients at the end of their life receiving better care Patients at the end of their life receive better symptom management Improved communication between staff, patients and relatives Improvements to the assessment of spiritual care for patients at the end of their lives	Colleagues feel more confident when delivering end of life care Colleagues feel more confident discussing all aspects of end of life care with patients and their families Colleagues feels more confident in identifying and treating symptoms that occur at the end of life
Lower Costs	**Patient/Service User/Care Experience**
Fewer complaints and issues raised (including RADAR reporting) for patients at the end of their life. Staff time is more cost effective as they are more confident in the delivery of end of life care	Patients receive better care at the end of their life Families receive better information about the dying process and what to expect, including symptoms Patients and their families receive better communication about the end of life

Staff are more confident and competent around the aspects of EOLC that could support patients discharges out of hospital at the end of life – therefore less inpatient bed days	Patients and their families have better conversations about aspects of TEP Patients and their families have an understanding of advance care planning and therefore wishes about preferred place of care and preferred place of death are expressed.

Project Disbenefits *(List any negative consequences arising from the change)*

- Immediate impacts – Majority of the mandatory teaching and trolley teaching sessions were planned and delivered by one member of the EOLC education team (KP) this places a significant impact upon one individual. If this should be taken up as the chosen way of delivering mandatory end of life care education there would need to be an improved method of delivering such work to ensure that the burden is not placed on one individual.
- The scale of delivery of mandatory education across the trust would be significant.
- The process of identification of those deemed to be requiring this mandatory education across the whole of SFT would require some discussion. Adapting and delivering the teaching to meet the needs of multiple professionals would require significant time investment from the EOLC education team, alongside the Learning and Development team.
- High costs incurred to deliver such teaching
- Ward closures due to infection prevented a number of trolley teaching sessions needing to be cancelled for Eliot ward in particular.
- Was 8 data points per ward (patient's deaths) an appropriate number to give an accurate reflection of the impact of the project?

Performance - Time and Cost

Timeframes *(compare the planned timescale v the actual timescale of the project, and the describe the reasons for any changes, both positive and negative)*

The timeframes and predicted dates for completion have met or been very close to the originally predicted timelines. Some challenges occurred with the requisition of medical notes for the end of project audit had caused a minor delay, however the education was delivered on schedule.

Project was delivered over a 6 week period, in quite an intense protocol of delivery of multiple mandatory teaching sessions per day. It is unclear if this method of delivery were to be expanded to the wider trust how the delivery would work. This method/design would require an intense commitment from the EOLC education team and other specialists to deliver this programme and this would be incompatible with the current staffing level. If this were to be taken up and delivered trust wide it would require a more spaced out and regularly allotted schedules for it to be delivered effectively; it could incorporate multiple sessions in one day but it would need careful consideration and planning. This would be quite labour intensive for the individual teaching the session as could require 6 hours of delivery in a one day period.

Other considerations to this method of delivery would be whether this course was to be delivered face to face, via teams or as prerecorded videos that were available to staff 24 hours a day on LEAP. If to be delivered face to face then room sizes and consistence of booking the rooms would need to be an additional consideration for the administration workload of the task – rooms at MPH academy can only be booked 3 months in advance and can be inconsistent with prioritisation of bookings (generally, medical student teaching getting the priority). If this was also to be delivered trust wide consideration would need to be made for staff from other clinical settings that were not just Musgrove would need to be made, so room bookings in community hospitals, at YDH or other settings (community hospitals) to ensure that there is equity across all sites and staffing groups.

If the 2 hour teaching sessions were to be made mandatory then a consideration would need to be made as to which staffing groups were to be included in this, and a plan would need to be made to determine how quickly this would need to occur, and if there was to be a rolling update programme (yearly, 2 yearly, 3 yearly etc). An adapted level of training could be created for different staffing groups e.g., admin staff, non-clinical staff, those who do not deliver hands on care; this has not been tested as part of this QI project.

Trolley teaching outcomes differ from the outcomes of the mandatory teaching sessions and delivery has less of an impact upon the EOLC education team. Part of future planning for this could include the delivery being conducted by other teams across the trust. When considering the impact of the trolley teaching, it should be of note that after the end of the project (November 2023) a programme of trolley teaching delivery was commenced on Dunkery ward to support the staff there. During this time the EOLC education team attended the ward on a number of occasions at differing times, it was noticed that the most successful time of delivery was between 10:00 and 11:00. There were more staff free to listen to the short teaching sessions as this time of the day fell at a lull in the ward routine and was before the middle day rush period. I should be of note that in future planning of this type of teaching that this would be a more successful time to plan trolley teaching.

Cost *(compare the budgeted v actual costs/savings of the project, and the describe the reasons for any changes, both positive and negative)*

The project did not set out with a budget for the delivery of education as it was as yet an unknown quantity. The education programme was devised, written, planned and delivered in house by SFT members of staff specifically employed to deliver education about palliative and end of life care (EOLC education team). There were however costs incurred due to the nature of development of the training resources, handouts, demonstration equipment etc.

- £650 for resource trolley – if this were to be made part of an ongoing curriculum for staff training an additional trolley and resource materials would need to be purchased and reproduced for the YDH palliative care team to use.
- Printing and laminating costs for the production of the trolley teaching reference booklet.
- Other admin/materials costs for the trolley training – folders, clipboards, Somerset end of life care and bereavement support website leaflets, "What to expect in the last days of life" leaflets, pens and other materials, RAG magnets, sweets for participating staff, physical props to demonstrate skills such as mouthcare.
- If the decision was made to convert the mandatory course to an e-learning package or for the delivery via videos this would have a production cost. The costs of which would depend entirely on who produced it and how long it would take, hourly costs of the in-house TEL team would differ greatly than from outsourcing the creation of a programme to an external company (£1500-£12,000).

There were also the considerations of costs of the delivery of teaching to the trust; hourly costs for educators for teaching as well as the hourly costs to the wards for the release of staff to attend.

- Time allocated for teachers (Band 6 hourly rate £18.01, band 7 hourly rate £22.37) – this is an essential factor when attendance is poor. A consideration would need to be made for the hours of preparation that goes into the development and planning of teaching as well as the delivery.
- Three times as much preparation time should be considered for each block of teaching (1 hour teaching, is equal to 3 hours of prep work) as well as additional considerations for the administration needs of running a face to face course such as room bookings, uploading dates to LEAP, writing and collation of evaluations. These costs would all need to be factors.
- Costs for ward releasing staff to attend teaching sessions (Band 2 hourly rate £11.45, Band 3 £11.67, Band 5 £14.53) – this should also be considered if staff are attending teaching sessions in their own time, this time given back in lieu of attendance will affect the hours worked on the ward. The costs to the wards are not only incurred in the time to release staff to attend teaching, but also in the "costs" of potentially being a member of staff down (if the attendance is during their shift time) and therefore what of that staff member's workload then is spread amongst their colleagues.
- Employment of an (or more) additional Practice Facilitator to the EOLC education team to deliver mandatory teaching regularly alongside the existing commitments of the EOLC education team (Band 6 staff member - £35,391 WTE per annum).

Reporting *(who was the project accountable to/who influenced it)*

End of Life Programme Board
CQC
SFT

Follow-on Actions

Transition to Business as Usual (BAU) *(outline the arrangements to transfer the project to operational directorates and staff)*

Further decisions about the project outcomes can be divided into the following categories. These options will be summed up later in this report. There will be a number of consequences for each of these actions, aligning this with the expectation of the CQC, as well as the capabilities of the education or specialist teams delivering the required outcomes.

- Do nothing.
  Continue to deliver the same level of education that existed prior to the project as highlighted at the start of this document. This could mean accepting the current standard of care which, as our small initial audit suggests, shows a low level of compliance with NICE QS across most domains.

- Do something.
  Choose certain aspects of the project that have worked well, invest the time and energy into establishing those as new standards of practice. In doing this it could create targeted topics for teaching from complaints, clinical errors, or changes in practice.

- Do everything.
  Establish a programme of mandatory delivery, trolley teaching and education boards for all identified staff members of SFT. This will have significant financial implications for the trust, as well as the likelihood of the need for at least one dedicated WTE employee for the delivery of such a programme.

If the 2-hour face to face mandatory teaching option is going to be taken up by the trust a larger plan would need to be undertaken to deliver such a piece of work; this would need to include an analysis of who the essential staff were for this teaching, and how they could be released from their working duties. A mapping exercise would need to be undertaken to ensure that appropriate staffing numbers were factored into the planning of any education package delivery.

It is the conclusion of the EOLC Education team that an approach to 'Do Something' should be the recommended path. In light of the development of a new IEOLCP for the Trust in 2024 (that will be structured around national EOLC guidance) there is an opportunity to roll out an educational package Trust wide to support with implementation of increased compliance with care standards.

Access (*outline any further access requirements (IT, physical, support, etc.))*

Depending on the model chosen there would be a varying requirement for support.

- If face to face access to numerous teaching rooms in various hospitals across the county would be essentials
- If e-learning, there would need to be an aspect of technical support for the maintenance of the module.
- If this were to be conducted on Teams, there may need to be an aspect of technical support required

Training *(outline any further training requirements (e.g., for new starters, refreshers etc)*

A consideration should be made if this teaching should be a one-off programme, or whether there should be regular updates given at intervals. New staff members would be expected to undertake this training as part of an induction to the trust and their new job role, and a roll out for existing staff would also be essential.

For the delivery it would be important to have all educators trained to the same standard – this may have cost implications to ensure that this standard was reached, educators may need to do additional CPD or study to get to that same standard.

As well as this a clear standardisation of the course content and learning outcomes would need to be agreed and written alongside the assurance of quality, standards, and governance over the content to ensure that all recipients of the training were reaching the same standard and continuity.

Information Governance *(what are the arrangements for auditing, data protection and any adjustments to the new change/service in BAU***)**

Ongoing requirement for staff records of attendance to be held – support from LEAP etc.
Ongoing need for audit – is this reflected in the NACEL audit, or would we need to find a way to demonstrate more of this in the form of audits that reflect education?

Benefits Reporting *(what are the arrangements for ongoing tracking and reporting of benefits from the change)*

There is an already established programme of national auditing of patients receiving end of life care (NACEL audit) that the trust partakes in; this could give some understanding of the progress of the impact of education.
It can be hard to establish the impact of education as an exclusive factor for improvements in care. Further work to improve the standards of care for dying patients is ongoing and therefore this work will have further assessment and audits going forward.

Future Plans *(what are the arrangements for further expansion/rollout; what, if any, are the conditions that need to be met to do this?)*

Recommendations following the project:

- Whilst this project has demonstrated that there is a positive impact on staff confidence in supporting those at the end of life, the stressors of clinical work cannot be overlooked when considering future education rollout. Staff struggle to attend training that is not

ringfenced as 'mandatory' due to clinical pressures, and even mandatory education still results in poor attendance rates. The question as to whether end of life education should be made mandatory is still one for discussion with the wider network, however the results of our audit show that there is a need for action to remedy some of the poor compliance rates with NICE QS 144.

- At present this audit data does not support the establishment of a mandatory teaching programme to be established. The costs of establishing such a programme requires too high a cost in terms of the development, delivery, and the attendance of staff for very little quantifiably clinical improvements. It is an option that should be considered at some point in the future in reflection of what is recommended by the CQC, however this project has not been able to establish a clear indication for it at present.

- Trolley teaching proved to be a simple and quick method to bring small amounts of education and crucially signposting to other education and resources options to busy staff. It would be the recommendation of this team that this method of education is employed more widely across the Trust, to increase not only education but also the presence of end of life care resources and support to staff. The results for the trolley teaching are encouraging and further development of this service would be beneficial to fully understand if the significant cost implications of this running trust wide would be impactful.

- The individualised end of life care plan is currently being under used, or this is not being reflected in the care that is given or documented. There will be development of a single trust wide end of life care plan and therefore this will give an opportunity to develop the education around these aspects of care. A result in this change in practice would be to encourage a renewal of enthusiasm and engagement with important key standards around palliative and end of life care, therefore improving the care given overall.

- Education delivery needs to be focused on a broad range of professionals to ensure the impact of this on to clinical practice. Within this project there was a mismatch on occasion around who received education and the practice that was assessed through the audit; a multiprofessional plan for education would help to mitigate this.

Communications *(is there a communications opportunity to promote and inspire continuous improvement across the organisation or wider?)* ***Have you published your PDSA postcards?***

Colleague Story *(Is there a real example of improved colleague satisfaction? If referencing identifiable information, please ask for consent. Otherwise please anonymise.)*

Following the end of the project on Eliot ward, the ward leader and ward link booked themselves onto a Communication in EOLC study day run by the EOLC education team at Musgrove. As a result of this the ward team have made a number of other future bookings for colleagues for dates in 2024, therefore highlighting the demand for additional end of life care training.

Clinical Safety (*describe any clinical safety arrangements before, during, and after the project)*

Ward staffing needed to be adequate and safe to deliver care before releasing staff to attend any of the teaching forms (both mandatory and trolley). This was probably reflected in the poor (40%) attendance rates of the mandatory teaching sessions as well as the low numbers of staff being available on the ward when the EOLC education team attended to deliver the trolley teaching.

Assurance from a governance perspective that the education delivered was of high standard and in line with current policy. This would reduce any clinical risks occurring due to misinformation being taught to staff attending the teaching.

Ward based teaching could be regularly dependent upon the infection prevention status of the participating ward areas. Ensuring that teaching staff were adhering to any infection prevention measures whilst meeting necessary education targets is an important consideration, or if the ward is closed due to infection that education staff do not attend those areas.

To maintain staff wellbeing when delivering teaching. An awareness of where to signpost staff for support if needed following training due to the emotive nature of some of the topics.

If the trolley teaching was going to be rolled out across the Trust, the manual handling involved in using the trolley over an extended period of time would need to be consider in line with LOLER regulations.

Risk Register *(comment on whether all risks have been closed or transferred)*

- Unable to deliver some teaching due to infection prevention ward closures – alternative arrangements made.
- Staff being pulled from the trolley teaching to continue clinical commitments of the ward.
- Staff unable to attend to mandatory training.
- Admin staff unwell on the ward areas and were unable to assist with the initial stages of the audit, therefore creating delays.
- Burden placed on one member of the team to deliver majority of the teaching leading to trainer fatigue.
- Continual commitment to be given by a small number of staff for delivery could also increase trainer fatigue.
- Staff shortages and sickness meaning which will impact or impede staff attendance for both mandatory and trolley teaching.
- Some members of staff would miss out on the delivery of aspects of education, creating a professional bias against shift workers (night staff in particular)
- The wards have scheduled MDT board rounds, ward rounds, drug rounds, breaks which means some staff are unable to join any trolley teaching.

Lessons Learned *(What are the highlights of the lessons learned throughout the project? These are usually both positive and negative.)*

- The scope of this project and the delivery of the education may not be considered strictly as a QI project. The aims of course, were to improve quality but in the strictest terms of how it was executed and actioned did not meet the QI process of a PDSA cycle. It could possibly be retitled and reframed as service improvement work to reflect how it was structured, and the practicalities of the work were conducted.
- Due to the number of factors affecting patient care it is difficult to directly assess how education impacts clinical work. Whilst our audit gleamed interesting results and highlighted areas for concern, we were unable to demonstrate that any changes occurred as a direct result of our education input.
- It would be unsustainable to rollout trolley or mandatory teaching trust wide with the capacity of the present EOLC Education workforce. The only education method that could be easily introduced would be the information boards, but it is difficult to ascertain the direct benefit of these.
- The 09:00 mandatory teaching sessions were poorly attended. This was assumed to be a poor start time due to individuals' home commitments. Therefore a 09:30 start time could mitigate this.
- Trolley teaching held better outcomes and engagement when delivered at a late morning slot.
- Trolley teaching also served as a high impact but low effort method of teaching delivery, staff were engaged and receptive to the teaching that was delivered in a quick manner.
- Trolley teaching enabled the delivery of education to a broad range of professionals on the wards thus ensuring that education was delivered in a way that was accessible to more people; as opposed to the mandatory teaching sessions that focused on delivery to nurses and healthcare assistants, therefore potentially limiting the impact of the teaching.
- Poor attendance to mandatory teaching is a trust wide problem, and therefore not necessarily related to the work that was conducted.
- Mixed methods for the delivery of education are an essential part in the formation of ongoing teaching planning.
- Considerations need to be made about the burden of delivery of teaching on individuals.
- Staff on the wards were clearly eager for education around end of life care and therefore going forwards staff enthusiasm for teaching should be harnessed and considered when planning for the future.
- Communication to staff about the availability of education needs to be improved – signposting staff to end of life care training is important to the success of the attendance. A robust communication and engagement plan is required to ensure appropriate dissemination of messages to all stakeholders involved.

Most staff were unable to provide feedback for trolley teaching via a QR code method as they did not have their mobiles on them. This could have been resolved with a paper form or via email, however this could have caused delays in receipt of feedback and in the real time reflection of this. Additionally, the quick nature of the magnet feedback meant the teaching session did not overrun.

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Appendix

Appendix A – CQC report for Somerset Foundation Trust in 2022

Appendix B – Audit questions

Appendix C – SFT Communications re: recruitment

Appendix D – Tweet

Appendix E - End of Life Care Education QI Project Letter to wards

Appendix F – Trolley teaching allocation of topics and staff

Appendix G – Photograph of the RAG magnets

Appendix H – Mandatory teaching allocation

Appendix I – Letter about mandatory training to staff

Appendix J – Audit results

Appendix A:

Trust - RH5 Somerset NHS Foundation Trust (23/01/2023) INS2-13546460131 (cqc.org.uk)

Appendix B:

4.0: Is there evidence in the patient record that it was recognised by the MDT that the patient is in the last days of life?

5.0: Is there evidence in the patient record that there was a discussion with the patient that the patient is approaching the last days of life?

6.0: Is there evidence in the patient record that there was a discussion with the patient's family that the patient is approaching the last days of life?

7.0: Does the patient have a LDL care plan?

8.0: Is anticipatory medication prescribed for the patient in LDL?

9.0: Is there evidence that the patient's spiritual/emotional health needs were discussed with the patient in last days of life?

10.0: Has hydration been discussed with the patient in the last days of life?

11.0: Has nutrition been discussed with the patient in the last days of life?

12.0: Has the patient's hydration been discussed with the patient's family in the last days of life?

13.0: Has the patient's nutrition been discussed with the patient's family in the last days of life?

14.0: Has a STEP Form been completed for the patient?

15.0: Was the STEP form completed within 12 hours of admission?

16.0: Is there documented evidence that the STEP was discussed with the patient?

17.0: Is there a resuscitation decision?

18.0: Is there a documented escalation treatment decision made?

19.0: Was a capacity option made?

20.0: Is the ‘What is important to me’ box completed?

21.0: If ‘consider hospital transfer’ or ‘may be for life prolonging treatment’ is ticked, is there a documented rationale in the ‘what is important to me’ box?

Appendix C:

Our news - (tfemagazine.co.uk)

End of life care education – opportunity for two adult wards

Our end of life care education team is seeking two adult wards to take part in a project about end of life care education.

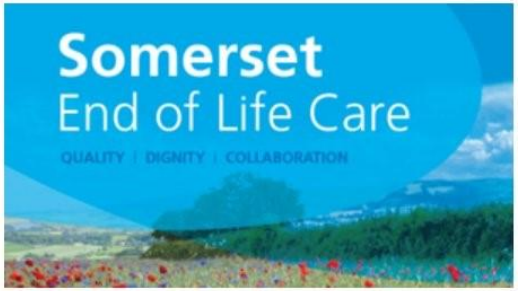
The project will help to improve end of life care on participating wards with minimal additional workload.

The team will provide the education and support on the ward for the teams, with a short amount of organised classroom time (approx. two hours), and will work with the ward management team to assess the impact of education on the care given.

For more information, please email EOLCEducation@SomersetFT.nhs.uk

Appendix D:

End of life care education – opportunity for two adult wards



Our end of life care education team is seeking two adult wards to take part in a project about end of life care education.

The project will help to improve end of life care on participating wards with minimal additional workload.

The team will provide the education and support on the ward for the teams, with a short amount of organised classroom time (approx. two hours), and will work with the ward management team to assess the impact of education on the care given.

For more information, please email EOLCEducation@SomersetFT.nhs.uk

Appendix E:

End of Life Care Education Team
Palliative Care Office
Old Building
Musgrove Park Hospital
Taunton
TA1 5DA
EOLCEducation@SomersetFT.nhs.uk
01823 343100

Dear Team/Ward Leads

End of Life Care Education QI Project

The Somerset NHS Foundation Trust 2022 CQC report recommended 'mandatory EoLC education' for relevant clinical staff working with individuals with life limiting conditions. Our team, in collaboration with the Learning and Development team, the Quality Improvement team and the Supportive and Palliative Care team are planning a project to consider whether mandatory end of life care education leads directly to improved outcomes for patients and their carers.

With this is mind we are seeking two wards to engage with this project. As ward/teams leads it is important that you understand the structure of the project and what support you would be required to give to it.

Stage One: Our team will audit Treatment Escalation Plans, Last Days of Life Care Plans (including observation charts) and the notes of patients who are dying/have recently died as inpatients on your ward. We will also hold a short focus group with a cross section of staff to discuss their confidence, skills and knowledge about caring for those at the end of life. For this we would need access to records as appropriate and for approx. 4-6 staff from in a cross section of roles to be released for half hour for the focus group.

Stage Two: Your ward would be randomly allocated into 'Mandatory' or 'Complimentary' in terms of the education your staff will received.

- The 'Complimentary' ward will receive ward-based information about EoLC education courses and resources, plus regular contact with the team for bespoke support and guidance, plus 'mini-sim' opportunities to help develop clinical skills around end of life care.
- The 'Mandatory' ward will receive all of the above plus a classroom based 2 hour introduction to palliative and end of life care course. Our team will work with you to ascertain the best model for staff to attend this course.

Throughout Stage Two it would be expected that team/ward leads will help signpost towards our services to raise the project's profile, and support staff to engage with education opportunities as appropriate.

Stage Three: A repeat of Stage One in order to gather comparable information to analyse.

The entire project is expected to take around 6-9 months to complete. As project collaborators you will be fully included on project write-ups and presentations both locally and nationally.

If you would like to be part of this project, or have any further questions, please email EOLCEducation@SomersetFT.nhs.uk by the end of April 2023.

We look forward to working with you to help improve end of life care for our patients across the Trust.

Kind regards

Somerset End of Life Care Education Team

Appendix F:

Trolley Dash Scheduling

Date	Time	Teacher	Notes	Topic
1st August	14:00-16:00	Karen, Amy M		Pain
10th August	14:00-16:00	Karen, Jo	Jo and Nic available	IEOLCP
14th August	14:00-16:00	Karen, Laura, Gemma		Communication
15th August	11:00-12:00	Karen, Amy M		Agitation
17th August	14:00-15:00	Laura, Gemma		TEP
22nd August	14:30-16:00	Amy M, Gemma, Laura		Mouthcare
29th August		Amy M, Karen, Amy G		TEP
4th September		Karen, Laura		Communication

Appendix G:

Appendix H:

Date	Room	Room booking times	EOLC ED TEAM TEACHER	Teaching Slot			
				09:00-11:00	11:30-13:30	12:00-14:00	14:30-16:30
31st July	**Tutorial 1**	**09:00-16:00**	Karen Laura	Manuel Gora Prince Dela Cruz Joy Adiele	Jobin Chakkalackal Babu Tanya Allen Melanie Smith		
1st August	**Tutorial 1**	**09:00-11:00**	Karen Amy M	Vicky Burgess Andy Capardo Mariano Gayantry Raju			
7th August	**Tutorial 1**	**09:00-16:30**	Karen Nic/Jo		Krizia Cristuta Bunmi Noel-Onukogu Tracey Lawrence		Martha Ndolvu Grace Somua Bansah Naomi Maunder
8th August	**Tutorial 2**	**09:00-15:00**	Karen Rob	Esther Erhabor Olive Ndanjoh Epse Dobinga Danielle Evans		Sherby Eappen Tamarabrakemi Timothy Hannah Goddard	
10th August	**Tutorial 1**	**09:00-11:00**	Karen Jo	Sneha Jogymon Zoe Osmond Megan Gregory			
14th August	**Tutorial 1**	**09:00-13:30**	Karen Gemma Laura	Elizabeth Gbadgesin Roseane Rodrigues Sumi Hossain Grace Somua Bansah	Lade Ogunleye Lita Salvacion Koyinsola Lawrenace		
22nd August	**Tutorial 3**	**09:00-15:00**	Amy M Gemma	Jency John Sonia Darvvin Anajli Pulparambil Sonia Joseph		Queen Agwu Anish Varghese Sajeesh Varghese	
29th August	**Tutorial 1**	**09:00-14:00**	Karen Amy M Laura	Simeon JR Tagacay Teena George Gemma Hughes Megan Gregory		Don Wickramaarachi Larissa Dunster	
4th September	**Tutorial 1**	**09:00-16:00**	Karen Laura	Mary Churchley Roseane Rodrigues Babitha Peter Pauline Wyatt Bridie MacCallum Mandy Lawrence Sajeeh Varghese Gayathri Raju		Chioma Enderline Ibe Aji Kudiyirippil	

Appendix I:

End of Life Care Education Team
Palliative Care Office
Old Building
Musgrove Park Hospital
Taunton
TA1 5DA
EOLCEducation@SomersetFT.nhs.uk
01823 343100

Dear

You may be aware that Eliot Ward are taking part in a QI project around the delivery of end of life care education. As part of this project, the End of Life Care Education Team will be delivering a 2 hour Mandatory teaching session titled "Introduction to End of Life Care."

The sessions will be taught in the Musgrove academy. If you are not due to be on shift at your allocated time, your time will be given back to you in lieu of attendance.

You will be expected to attend this teaching in the allocated slot (see below for details) in the same way that you would attend your basic life support or moving and handling training.

However, if you have a problem with your attendance of the course on the allocated time slot please do get in touch with us on the above email and we will rearrange a time that is more convenient.

Please attend the teaching on:

Date:

Time:

Location:

We will look forward to meeting you soon.

Kind regards,

End of Life Care Education Team

Appendix J:

Clinical Audit Title: Last Days of Life Care Plan and Treatment Escalation Plan Audit **Registered audit number:**	
Clinical Audit Proposer:	Laura James
Clinical Audit Supervisor:	Dr Jo Lutyens
Site (please delete sites not applicable)	MPH
Specialty/Ward/Department:	Eliot/Dunkery/Beacon
Data Period:	10.07.2023 – 4.12.2023
Report Date:	
Name of group/team/service/person agreeing plan:	
Date report and action plan presented and agreed:	

Contents

Appendices

NHS Somerset NHS Foundation Trust

CLINICAL AUDIT INFORMATION

Background of audit topic/reason for audit being required:
To audit the notes of (min.) 24 patients across 3 wards (Eliot, Beacon and Dunkery wards) (8 per ward) identified as being nearing the end of life to ascertain how their care meets NICE QS13/144 and TEP policy standards as part of a wider QI project looking into how best to deliver mandatory end of life care education Trust wide. Notes will also be audited after the education delivery period to note how/if education is impacting clinical care.

Clinical Audit Objective(s):
The audits will be used to measure the compliance of wards with NICE QS13 standards.

Benefit to patient/client:
Improved EOLC that better meets NICE QS. Improved discharge process. Improved care after death and bereavement support for families.

Scope of the audit:	[x] Local	[ ] Regional	[ ] National	[ ] Collaborative

Source of Standards (please tick ✓ and state name of document):		
National Guidance e.g. NICE (please state)		NICE QS 13 AND 144
Trust protocol/guidance/policy (please state)		TEP POLICY
Risks/incidents/complaints (please state)		
Other (please state)		CQC REPORT 2022

Methodology (including details of numbers of patients, how sample was selected etc. – see Audit Plan):
A total of 25 patients were audited at the beginning of the QI project and an additional 23 were audited at the end of the project bringing our data total to 48. The first was selected with help of the bereavement team identifying deaths across the 3 wards between May 23 and early July 23. In order to get the sample size desired, on one occasion we had to go back to April 23 records. The second sample was collated in the same manner, with deaths taken from the beginning of August 23 through to Oct 23 across the 3 wards. The MRNs of the patients were then given to our admin team to recall the notes, the audit was carried out by manual review and the data was then inputted into the Questback online collation tool.

SUMMARY OF RESULTS

Date period: April – July 2023

STANDARD		REFERENCE	EXCEPTIONS	TARGET (%)			Dunkery (Control) COMPLIANCE *% and numerators / denominators*	Beacon (Trolley) COMPLIANCE *% and numerators / denominators*	Eliot (Trolley/Mand.) COMPLIANCE *% and numerators / denominators*
				%-% (Red)	%-% (Amber)	%-% (Green)			
1	It should be recognised by the MDT that the patient is in the last days of life	NICE QS144: Statement 1 End Of Life Care Policy Point 5	None	<80	80-90	91-100	77 (9)	100 (7)	100 (9)
2	It should be discussed with the patient that the patient is approaching the last days of life	NICE QS144: Statement 2 End Of Life Care Policy Point 8	Patient unconscious Patient lacks capacity Patient did not wish to discuss	<80	80-90	91-100	78(9)	86 (7)	89(9)
3	It should be discussed with the family that the patient is approaching the last days of life	NICE QS144: Statement 3 End Of Life Care Policy Point 8	Patient did not consent to family being involved Family did not wish to be involved Patient has no family	<80	80-90	91-100	100(9)	100(7)	88(9)
4	Each patient identified as being in the last days of life should have a LDL care plan	NICE QS144: Statement 1 End Of Life Care Policy Point 5	None	<80	80-90	91-100	89(9)	57(7)	66(9)
5	Anticipatory medication should be prescribed for the patient in LDL	NICE QS144: Statement 2 End Of Life Care Policy Point 8	Patient died within 24hrs of being recognised they were going to die	<80	80-90	91-100	100(9)	86(7)	83(9)
6	Spiritual/emotional health needs should be discussed with the patient in last days of life	NICE QS144: Statement 4 End Of Life Care Policy Point 8	Patient unconscious Patient lacks capacity Patient did not wish to discuss	<80	80-90	91-100	78(9)	86(7)	55(9)

7a	Hydration and nutrition should be discussed with the patient in the LDL	NICE QS144: Statement 4 End Of Life Care Policy Point 8	Patient did not consent for discussion with family Family declined to discuss Patient has no family	<80	80-90	91-100	78(9)	42(7)	56(9)
7b	Hydration and nutrition should be discussed with the patient's family in the LDL	NICE QS144: Statement 2 STEP & Resuscitation Decision Policy End Of Life Care Policy Point 7	Patient unconscious Patient lacks capacity Patient did not wish to discuss Did not consent for discussion with family Family declined to discuss Patient has no family	<80	80-90	91-100	33(9)	14(7)	11(9)
8	A TEP should be completed for the patient identified to be in the LDL	NICE QS144: Statement 2 STEP & Resuscitation Decision Policy End Of Life Care Policy Point 7	Patient dies within 4 working hours of need for TEP being identified?	<80	80-90	91-100	100(9)	100(7)	89(9)
9	All in-patients (except paediatric, obstetric and day-case patients) must have a STEP form completed at or around the time of admission	STEP policy Appendix C & D	Patient lacked capacity – discussed with LPA If patient declines	<80	80-90	91-100	89(9)	86(7)	62(9)
10	There should be documented evidence of the discussion with the patient	STEP policy Appendix E	If patient lacks capacity, then an LPA documented If patient declines	<80	80-90	91-100	67(9)	72(7)	38(9)
11	There should be a resuscitation decision completed (Do not attempt CPR or Do attempt CPR)	STEP policy Appendix E	If patient declines Patient lacked capacity – discuss with LPA	<80	80-90	91-100	100(9)	100(7)	100(9)
12	There should be a documented escalation treatment decision made	STEP policy Appendix E	If patient declines	<80	80-90	91-100	78(9)	100(7)	100(9)
13	A capacity option should be made	STEP policy Appendix E	None	<80	80-90	91-100	78(9)	14(7)	12(9)
14	The 'What is important to me' box should be completed	STEP policy Appendix E	If patient declines	<80	80-90	91-100	44(9)	72(7)	38(9)

15	If 'consider hospital transfer' or 'may be for life prolonging treatment' is ticked, there should be a documented rationale for the 'what is important to me' box	STEP policy Appendix E	If patient declines	<80	80-90	91-100	11(9)	n/a	13(9)

Date period: Aug - Oct 2023

STANDARD		REFERENCE	EXCEPTIONS	TARGET (%)			Dunkery (Control) COMPLIANCE *% and numerators / denominators*	Beacon (Trolley) COMPLIANCE *% and numerators / denominators*	Eliot (Trolley/Mand.) COMPLIANCE *% and numerators / denominators*
				%-% (Red)	**%-%** (Amber)	**%-%** (Green)			
1	It should be recognised by the MDT that the patient is in the last days of life	NICE QS144: Statement 1 End Of Life Care Policy Point 5	None	<80	80-90	91-100	100 (8)	100 (7)	100 (6)
2	It should be discussed with the patient that the patient is approaching the last days of life	NICE QS144: Statement 2 End Of Life Care Policy Point 8	Patient unconscious Patient lacks capacity Patient did not wish to discuss	<80	80-90	91-100	89(8)	89(7)	83(6)
3	It should be discussed with the family that the patient is approaching the last days of life	NICE QS144: Statement 3 End Of Life Care Policy Point 8	Patient did not consent to family being involved Family did not wish to be involved Patient has no family	<80	80-90	91-100	100(8)	100(7)	67(6)
4	Each patient identified as being in the last days of life should have a LDL care plan	NICE QS144: Statement 1 End Of Life Care Policy Point 5	None	<80	80-90	91-100	63(8)	55(7)	50(6)
5	Anticipatory medication should be prescribed for the patient in LDL	NICE QS144: Statement 2 End Of Life Care Policy Point 8	Patient died within 24hrs of being recognised they were going to die	<80	80-90	91-100	75(8)	100(7)	89(6)
6	Spiritual/emotional health needs should be discussed with the patient in last days of life	NICE QS144: Statement 4 End Of Life Care Policy Point 8	Patient unconscious Patient lacks capacity Patient did not wish to discuss	<80	80-90	91-100	75(8)	44(7)	83(6)

7a	Hydration and nutrition should be discussed with the patient in the LDL	NICE QS144: Statement 4 End Of Life Care Policy Point 8	Patient did not consent for discussion with family Family declined to discuss Patient has no family	<80	80-90	91-100	75(8)	22(7)	50(6)
7b	Hydration and nutrition should be discussed with the patient's family in the LDL	NICE QS144: Statement 2 STEP & Resuscitation Decision Policy End Of Life Care Policy Point 7	Patient unconscious Patient lacks capacity Patient did not wish to discuss Did not consent for discussion with family Family declined to discuss Patient has no family	<80	80-90	91-100	0(8)	22(7)	50(6)
8	A TEP should be completed for the patient identified to be in the LDL	NICE QS144: Statement 2 STEP & Resuscitation Decision Policy End Of Life Care Policy Point 7	Patient dies within 4 working hours of need for TEP being identified?	<80	80-90	91-100	89(8)	100(7)	100(6)
9	All in-patients (except paediatric, obstetric and day-case patients) must have a STEP form completed at or around the time of admission	STEP policy Appendix C & D	Patient lacked capacity – discussed with LPA If patient declines	<80	80-90	91-100	50(8)	100(7)	83(6)
10	There should be documented evidence of the discussion with the patient	STEP policy Appendix E	If patient lacks capacity, then an LPA documented If patient declines	<80	80-90	91-100	42(8)	78(7)	67(6)
11	There should be a resuscitation decision completed (Do not attempt CPR or Do attempt CPR)	STEP policy Appendix E	If patient declines Patient lacked capacity – discuss with LPA	<80	80-90	91-100	100(8)	100(7)	100(6)
12	There should be a documented escalation treatment decision made	STEP policy Appendix E	If patient declines	<80	80-90	91-100	75(8)	100(7)	100(6)
13	A capacity option should be made	STEP policy Appendix E	None	<80	80-90	91-100	24(8)	78(7)	50(6)
14	The 'What is important to me' box should be completed	STEP policy Appendix E	If patient declines	<80	80-90	91-100	0(8)	67(7)	83(6)

15	If ‘consider hospital transfer’ or ‘may be for life prolonging treatment’ is ticked, there should be a documented rationale for the ‘what is important to me’ box	STEP policy Appendix E	If patient declines	<80	80-90	91-100	0(8)	22(7)	0(6)

CONCLUSIONS

Explanations for any reasons of non-compliance, if known, per standard
There are areas for concern across the audit data. There are several standards linked to communication with the patient around their end of life care and the fact that they are dying that are consistently poorly reported. The standards around hydration and nutrition are not met. Capacity is rarely recorded on the TEP forms and there is often little detail to personalise the TEP form, e.g. 'what matters to me'.

Have the Clinical Audit Objectives been met *(include details per objective)***?**
The audit demonstrates ward compliance with NICE QS 144 and demonstrates the areas for concern, but it is important to note that the samples sizes are fairly small and as such it is difficult to determine if changes are directly influenced by increased education input, or lack of. However it clearly underlines that there are some areas where compliance is very minimal and as such action is needed to remedy change.

Reflections/observations on local practice
Overall there are some domains where we can celebrate best practice, but there is also plenty of scope to support wards to develop targeted improvements to certain standards. The duration and sample size of this audit is probably insufficient to note any direct impactful change of an education programme, but it gives a overall sense of the areas of concern to target future education.

Key strengths identified
Recognition of the patient approaching the end of life is generally well documented by the wards. JIC meds are being used regularly in the majority of cases. The wards are overall communicating to families that their loved one is dying. TEP resuscitation decisions are documented in all occasions, and escalation decisions are mostly documented too.

Key areas for improvement *(include any standard not achieving the agreed target, and consider addressing in action plan)*
Communication with the patient at the end of life should be better, to understand more about their emotional, spiritual, nutrition and hydration needs. Care plans should be utilised more. Treatment Escalations Plans need to be universally improved.

REFERENCES *(delete if not applicable):*

RE-AUDIT CALCULATOR

This calculator is a simple guide to help determine when/if a re-audit is required and should be used to assess the need for ALL clinical re-audits.

The calculator will help to:

- Manage resources including time.
- Assess the need/frequency of a **FULL** re-audit (any additional plan-do-study-act/rapid feedback cycles on actions should be included within the action plan of the audit)

Clinical teams driving their own audit may wish to work on a more rapid re-audit cycle than suggested below, and policy-based assurance audits may require a rolling re-audit at least once every 2 years (or as stated in the policy), regardless of the actual score calculated.

When using this calculator please consider the general overall findings and the agreed actions of the audit (including timescales). Please complete a score in each box and use the total at the bottom to determine the need for re-audit.

FACTOR	RANGE:	SCORE:
Compliance: How concerned are you about your findings?	1 = low concern - 5 = high concern	**5**
Variation: How much difference in practice have you seen between the services/teams/clinicians included in this audit?	0 = no variation 1 = low variation 5 = high variation	**5**
Other monitoring available: Is there any other ongoing/planned monitoring covering this particular subject (e.g., improvement project, balanced scorecard, Trust action plans etc), or is audit the only measure?	1 = multiple monitoring 5 = no other monitoring	**3**
Significance of changes required: How big are the changes in the action plan? *(Other planned changes across the organisation could drive this score.)*	1 = minor changes 10 = major changes.	**8**
Total score:		**21/25**

Score	Date to consider re-audit:
20 – 25	Consider re-audit in the **next** financial year
14 - 19	Consider re-audit in the next two financial years
8 - 13	Consider re-audit in the next three financial years
3 - 7	**Consider if a further re-audit is required at all**. (N/A for policy assurance audits)

AUDIT LEAD TO COMPLETE, GROUP REVIEWING REPORT TO DISCUSS AND AGREE:

Score	Re-audit date calculated by audit lead:	Re-audit date agreed by group:	If dates are different, please state reasons:

Please include re-audit as part of your action plan

Action Planning guidance (please delete this page after writing your action plan)

Areas that have been identified as 'Requiring Improvement' often require multiple actions /interventions to improve the care we give to our patients rather than a single change; these changes are most successful when they do not rely on people simply remembering to do the right thing and will increase the likelihood that the improvement will stick.

There are some actions that are least likely to result in improvement if they are relied on as the sole change; this is not suggesting that these are not important changes - they can form the bedrock to support other changes but need to be accompanied by other actions/interventions to result in maintained improvement. Purely attending a training course or reading a policy might make a temporary improvement but this may not result in embedded change.
The table below is a guide to enable you to identify the most successful types of actions, and when they might benefit from being accompanied by additional actions:

Types of actions that make it hard to do the wrong thing and do not depend on staff to remember to do the right thing (most reliable, strongest actions): • Forcing functions or physical stops that prevent incorrect actions/omissions. • Duplication of critical functions (such as checking patient ID) • Simplify the process and remove unnecessary steps to reduce workload. • Action by leadership in support of patient safety
Types of actions that make it easy to do the right thing, spot and prevent errors (somewhat reliable actions): • Checklists for high-risk procedures • Forced pause in a process to recheck details and steps. • Reminders • Standardisation of equipment and supplies • Build time into the process to self-check or double-check work for errors
Types of actions that depend on staff to *remember* what to do (Least reliable as the **sole** action) • Education and training alone • Updating/writing rules, policies and procedures alone

For example, if it had been identified in an audit that care plans are poorly completed, your actions could include all the following, (rather than just stopping at the first one):

Education/training – Trust training sessions (classroom based, virtually or online) to increase knowledge/act as a reminder of what is needed any why.

Reminders – this could be via posters, continual discussion at team meetings, monthly updates to emphasise importance of full completion.

Simplify the process – Review care plan document – are there areas included that perhaps people find hard to complete or didn't know they had to complete? Could there be areas that might be considered unnecessary, and proposals put forward to possibly remove? Did your audit confirm these as being the areas that are regularly left incomplete?

Action by leadership – perhaps review 6 care plans during each clinical supervision session, and monthly/quarterly monitoring of a small sample to ensure full completion with good quality information.

Policy – check the policy wording reflects any changes in approach.

Please remember that each individual action should incorporate SMART principles, i.e., have a named owner, and a target date for achievement, all recorded on the action plan overleaf.

ACTION PLAN

ACTION PLAN To meet gaps identified in Audit Last Days of Life Care Plan and Treatment Escalation Plan Audit	Date action plan initially created:	11.12.2023

Plan Owner:	Laura James	Group/Committee:	*EOL Programme Board*
Core implementation Group:	*EOLC Education Team/Learning and Development Team*	Date last updated: (and version no):	
		Next review date:	
Links to key documents –			

Action What specific actions will be taken to address the issue(s)	Led by (Name of person):	Achieve by (date):	Progress update / notes	Status
Issue 1: *(add issue heading – see Key Areas for Improvement)*				
1.1 Supporting staff to improve communication with patient at the end of life about their care needs	*Add name*	*Add date*		
1.2 Supporting staff to communicate with the patient that they are coming to the end of their life				
Issue 2: *(add issue heading – see Key Areas for Improvement)*				
2.1 Improvements overall to the completion and use of TEP				

Action What specific actions will be taken to address the issue(s)	Led by (Name of person):	Achieve by (date):	Progress update / notes	Status
2.2 Use of a Trust wide EOLC Care Plan				
Issue 3: *(add issue heading – see Key Areas for Improvement)*				
3.1				
3.2				
Issue 4: *(add issue heading – see Key Areas for Improvement)*				
4.1				
4.2				

Measures of success of Action Plan - How will we know if improvements have been made?	
Monitoring method (e.g. re-audit, spot check, document produced):	**What issues / action in the plan does this cover?**

Status tracking		
Complete	**Green**	**G**
On plan	**Blue**	**B**
Risks slippage	**Amber**	**A**
Barriers – not achieved	**Red**	**R**