

Peer-reviewed papers

Solution Focus: A methodology for workshops to train hospital staff in end of life conversations and documentation

Emily Mckean

Abstract

This case study looks at using a solution focused (SF) methodology to design workshops to empower hospital employees to engage in end of life conversations and documentation. It looks at how SF influenced the design, implementation and evaluation of the workshops. Recommendations for future training and staffing are made.

Introduction

The post of End of Life Care Facilitator was created for one year and funded via a St James' Place Foundation/Hospice UK grant for a project entitled '*Hospice facilitation of training [acute trust] healthcare professionals in end of life care discussions and planning*'. This article illustrates why and how this facilitation was delivered using a SF methodology and will provide recommendations on how future training could be delivered to increase the confidence of individuals to initiate, continue and document end of life conversations and advance care planning.

Address for correspondence: Centre for Health Services Studies, University of Kent, Canterbury, Kent CT2 7NF, United Kingdom

Context and rationale

The stated aim of the project was to facilitate training for healthcare professionals in an acute hospital trust in end of life discussions and documentation, thus promoting a patient-centered approach to hospital discharge to their preferred place of care and death and to make changes that improved coordination and quality of end of life care (EoLC). Hospital teams were prioritised for training because they care for the patients before discharge from hospital to their preferred place, leading to a direct impact on patient care.

The project objectives were to:

- increase the number of practitioner-led EoLC discussions and planning resulting in more patient preferences recorded;
- increase the number of patients being cared for in their preferred place (and decrease hospital deaths) – congruence between preferred and actual place of care;
- improve confidence and competency of trained hospital staff measurable using self-report questionnaires.

Initially, the primary outcome was for staff to identify and record patient preferences on an Electronic Palliative Care Coordination System (EPaCCS) wherever possible. EPaCCS is an IT system that provides access to patient information for professionals across different settings (Croucher & Rhodes, 2013) and could have provided a useful tool around which to focus training and also evaluation of the success of the project. Accommodating individual care preferences through staff training and forums for partnership working, driven by a facilitator, are practical and established activities to improve the service (NHSIQ, 2013a; Wye et al., 2012; Croucher & Rhodes, 2013). In the London EPaCCS project, 78% of patients' preferred place of death was being achieved (NHSIQ, 2012).

At the time of the project hospital staff were restricted to 'view only' access to the EPaCCS system. Therefore the project could not be measured through an increase in

recording on EPaCCS, and the system could not be used to measure the congruence between preferred and actual place of death. The third item of confidence and competence measured by self-report questionnaires pre and post workshop was therefore the selected outcome measure for the project. Delivering training on EoL conversations and documentation requires a wide range of topics to be covered, which would be difficult to present in a linear powerpoint didactic teaching session. As well as the areas outlined in the *Five Priorities of Care for the Dying Person* (NHSIQ, 2014), there are also elements to include in an Advance Care Plan (ACP) such as Advance Decision to Refuse Treatment (ADRT) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Advanced communication skills are also a key element in Advance Care Planning, and this training was not part of the project brief.

It was therefore decided that the most appropriate approach to achieve the aim of the project was solution focus (SF) as it is based on building on existing knowledge and skills (Kennedy & Coombs, 2011). As facilitator, the position was taken of not being the expert and participants were credited with having a great deal of knowledge and experience to share with each other in order to achieve their goal of improved knowledge and confidence in Advance Care Planning. The SF coaching model of OSKAR as described by Jackson and McKergow (2007) was used to shape the workshops and to keep them solution focused. The SF principles also provided guidance to the facilitator to remain solution focused and avoid 'problem talk'. Problem talk was considered to be unhelpful in the workshop as dwelling on past errors or poor practice will not help people to move on, learn or change. Solution-focused talk enabled the facilitator to uncover participants' hidden resources and to become more naturally pro-active by focusing on an ideal future. Negative beliefs or experiences are acknowledged but positive aspects highlighted such as personal strengths, examples of good practice or good communication skills. These provided real life experiences for the rest of the group to learn from.

The SF methodology and the workshop intervention

OSKAR (Jackson & McKergow, 2007) stands for Outcome, Scaling, Know-how and resources, Affirm and action, Review. It is a framework for SF coaching and was chosen as it has been tested and used to help the coach focus on conversations and help participants find a way forward. The model was adapted to suit the workshops and also influenced by Kennedy & Coombs' (2011) approach to their workshops. There was a pilot session in which the method and the questionnaires were tested and feedback was gained.

The workshops began with an explanation of the project and facilitator background and most importantly the question: *"What would need to happen here today for you to feel that this was a worthwhile session?"* This was written down on a flip chart and returned to at the end of the session to illustrate that individual session goals had been met. This enabled the session to meet individual needs, the content of it shifting according to those needs. This question also helped to set the scene and the expectations of both participant and facilitator and encouraged those who mostly wanted talk about problems on the ward to engage in solution focused talk.

S – Scaling. A scaling questionnaire was provided before and after the session (Table 1). The questionnaire was designed to track changes in perception of confidence in different areas on end of life discussions and conversations.

Platform. – This was a short taught section about end of life conversations and documentation as well as ACP, DNACPR, ADRT: what they are and what the literature and guidance says. This was a basic summary to ensure that all grades and professions understood the basic principles of end of life conversations and documentation before the group work began to provide a platform to work from.

O – Outcome. Participants were split into groups of 3 or 4 and asked: *"You are a patient. ACP is working really well. What would that look like?"* This future-focused question asks participants to think of the 'future perfect', where there is the

desired outcome without problems but also recognises what is happening now (Jackson & McKergow, 2007). This activity allowed participants to teach each other what could constitute an ACP and to share elements of their practice. Inevitably stories of ‘failed’ discharges and traumatic experiences arose. The SF approach encouraged the facilitator to listen to what was being said, ask questions and draw out the elements of good practice that were always hidden within the frustrated tale of the failed discharge. It also enabled an acknowledgement of the ways in which the health and social care system may prevent a ‘good discharge’ no matter how hard an individual may work to help the patient achieve their preferred place of care/death and to reiterate that the individual worked hard and did their best.

K – Know-how and resources. Once the groups had fed back their perfect ACP they were asked: “*What are the next steps toward the perfect ACP you described?*” After creating a vision of the perfect ACP, participants thought about what the next steps to this ideal were. Common answers included:

- improved communication
 - interdisciplinary
 - with patient/family in out-patients and in the community, not just in the acute setting
- better IT to share preferred place of care/death and do not resuscitate with all settings and ambulance service
- advanced communication and advance care planning training for all staff
- individual professions to take ownership of their role in advance care planning
- staff to have time to reflect and give/get feedback.

A – Affirm and action. With these next steps in mind, the participants were asked to think individually about what small step they could make toward the perfect ACP by selecting a small part of the perfect ACP identified in the first session that they could personally do. These were written on a post-it note and given to the facilitator. This allowed choice instead of

solutions imposed on them. It became obvious that they knew best the issues they are facing and how to approach them. Some people chose personal as well as professional baby steps:

- ‘Initiate difficult conversations as soon as possible so that opportunities are not lost.’
- ‘Clearer objectives and more personal confidence in approaching patients and discussing in advance the end of life care plan.’
- ‘Ask families at complaint meetings what improvements can be made to EoLC and feed back to clinicians involved.’
- ‘Talk to my partner re death.’ ‘Read up more on the EoLC planning in UK and abroad.’
- ‘Listen to the patient who wishes to be involved in their care.’ ‘Talk about death.’

Facilitator action was to point to resources available and email them further details after the workshop if needed/requested.

20 workshops were planned in an eight month period. Five sessions were cancelled due to poor attendance. Ideally, workshops would have had 6–11 people of different professions and grades, as these promoted the liveliest debate and effective information sharing. As physician attendance was low, the workshops were provided at three F2 doctors’ training sessions where attendance was 10–12. It was also requested that the workshop was provided at a day surgery and theatre practitioner study day with 25 participants. For these more homogeneous groups, the workshop was delivered with the same basic structure but adapted to meet the needs of the participants. For example, the F2 doctors would arrive at different times and were reluctant to speak in front of each other. Therefore the facilitator would start the session with the Dying Matter film about Dr Kate Granger to help set the scene and expectations. In the film Dr Granger talks about moving from the role of doctor to patient, her thoughts on death and her “#hellomyname is” campaign, which aims to improve communication in hospitals (Kate’s Story, 2014).

R – Review. Approximately one month post-session, the facilitator emailed participants to ask how they were getting on with their baby step toward the perfect ACP. Prompts regarding what could be done if they had not managed their step were provided and the facilitator offered to identify how she could help. Response to these emails was limited (16/106) but showed an interesting spectrum of responses to the training and to the implementation of a small change in a busy and stressful environment. Some felt unable to initiate conversations about ACP as they were too busy. Another was keen to provide information to her patients regarding keeping their DNACPR safe. When this baby step was followed up, the participant reported trouble finding the information required. Therefore, the facilitator found the information and forwarded it to the participant to action.

Another participant identified the need for a ‘toolkit’ of helpful phrases which was sent to them after the session:

“I led my first DNAR conversation independently with a patient last week, and the phrases were useful to start the conversation – I know in the past I would have found this very daunting, but the conversations have helped me think about how to start off these conversations.”

They go on to say that the session:

“... introduced the idea of providing holistic care in whichever capacity we have – primary or secondary care, emergency or otherwise – it made me realise there were some small steps I could implement. Now I feel more confident about my role within the team and what it is I can contribute.”

This is illustrative of the power of this form of workshop, whereby participants feel more confident to engage in EoL conversations as they have been empowered to take a small step toward the ideal future of the perfect advance care plan and feel supported by the group and the facilitator.

S – Scaling. Post workshop questionnaire.

Before and after the workshop, a questionnaire that asked the participants to scale from 1–10 (not very confident – confident) their confidence in certain areas of end of life conversations and documentation was provided (table 1). The average score of the 85 respondents was collated and an increase in confidence was seen in all the questions (figure 1).

Table 1
Questionnaire and results

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1. How confident are you in initiating conversations about preferred place of care with a patient?
 2. How confident are you in continuing these conversations?
 3. How confident are you initiating conversations about preferred place of care with family/carers?
 4. How confident are you in continuing these conversations?
 5. How confident are you in having conversations about DNACPR with patients?
 6. How confident are you in having conversations about DNACPR with family/carers?
 7. How confident are you that you know what to do when a question is asked that you are unable to answer?
 8. How confident are you in the documenting of Advance Care Plans?
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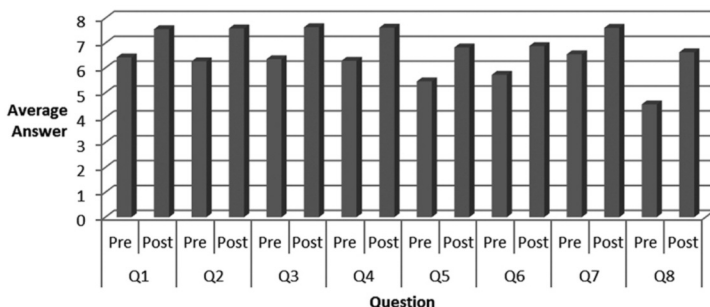


Figure 1. Average score pre & post workshop questionnaire results

A scaling tool was used in the questionnaire so that the participants could objectively decide how confident they feel before and after the training. The use of scaling gives the participant the opportunity to recognise even small increases in confidence (Jackson & McKergow, 2007).

Conclusion

It was found that the benefits of this SF approach to EoL conversations and documentation training were:

- flexible and easily tailored to needs of participants and different groups of professions and bands, whilst covering all the areas involved in EoL conversations and documentation;
- can be used with homogeneous groups, but varied groups increased information sharing and improved the learning experience. It also helped professions to recognise everyone has a part to play and that many are feeling the same way about the subject or are ‘all in the same boat’. This also helps to reduce the blame culture and the feelings that EoL conversations are someone else’s responsibility;
- the group were empowered to take a small but manageable step towards the ideal, which provided motivation and increased confidence and self-efficacy. It will also promote personal responsibility for their small step toward the ideal but for the whole system;
- sharing experiences both good and bad with the facilitator always focusing on the good practice rather than the ‘failed discharge’ helped to share real life examples of good practice, whilst acknowledging that sometimes no matter how hard we try a situation will not work out the way you or the patient want it to due to external influences that cannot be controlled.

For these reasons it is possible this form of training could contribute to a reduction in staff burnout, benefiting staff and

healthcare as a whole. It is recommended that a dedicated EoL Facilitator is employed at each of the Trust's three hospital sites. A local EoLC Facilitator would:

- roll the SF training out all year round together with advanced communications training, which would also have a SF methodology;
- go on to the wards to support staff to achieve their baby steps and for them to share their knowledge with other staff members. Provide a sounding board to help staff to think about their practice and good or bad experiences;
- support EoL link nurses on wards to be empowered to promote cultural change and good practice. This would then free up Palliative Clinical Nurse Specialists to do their clinical work. The EoLC Facilitator could also cover any other generic EoL work that does not require a specialist nurse;
- provide training to every new set of F1 doctors in order to really start to influence the culture and therefore improve patient experience and outcomes. There could also be an EoL element to the staff induction;
- represent staff at working groups or meetings, such as the EoL documentation working group, to ensure the staff voice is heard and that outcome of the meetings is fed back to interested parties;
- foster links with community EoL Facilitators, GPs and the local Hospice and feed back community developments to ward staff. Introduce an SF approach in meetings;
- champion Share My Care/provide training on whatever EPaCCS system is put in place in the future.

This role would help the trust to meet the needs identified by staff in the second group activity of how to achieve perfect ACP which included: improved communication (interdisciplinary and with patient/family), better IT to communicate patient wishes, advanced communication and advance care planning training for all staff, individual professions to take

ownership of their role in ACP, staff to have time to reflect and give/get feedback to foster a culture where staff are informed, engaged and empowered regarding EoL conversations and documentation, but have confidence that wider issues are being tackled by management and are not their personal responsibility.

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Emily Mckean is an Occupational Therapist (OT) whose experience and interests include project management, teaching OT students, end of life care, occupational therapy and solution focused methods. She has a BSc in Occupational Therapy and an MSc in Advanced Practice – Occupational Therapy. She was using her clinical experience to lead a one year project as an end of life care facilitator, providing training to local hospital trust staff on end of life conversations and documentation. She won a Health Services Research scholarship and has started a Social Policy PhD at the University of Kent, looking into the lived experience of end of life care. ejmb2@kent.ac.uk