Advance care planning (ACP) is a process of reflection and communication, in which a person with decision-making capacity is able to express their wishes, regarding preferences for their treatment at end of life. It is a process that enables families, residents and staff to discuss wishes and preferences for end-of-life care in a manner that respects autonomy, preserves relationships and ensures that care is planned in a way that supports high-quality, value-based care.

**Aims**

The study aimed to explore staff, residents and families’ experience of participating in ACP discussions. A qualitative descriptive study was undertaken in three nursing homes implementing the GSFCH programme. Twenty-eight interviews were carried out. Five main categories arose: understanding ACP; undertaking ACP discussions; the impact of ACP discussions; use of documentation; and, relationship and rapport.

**Results**

Families found comfort that their loved one’s future care had been considered. They felt reassured by the involvement of the family and staff in decisions. Residents were open to having ACP discussions, and were able to express wishes regarding preferences for their end-of-life care.

The assistance of a trained facilitator helped staff to develop the knowledge and skills required to deliver ACP discussions. The use of tick-box approaches was useful for prompts but limited the depth of their discussions with families and residents. The use of documentation either acted as a useful prompt or limited the discussion. Staff had to face their fears around discussing death and dying. The newly formed, three-component network for Worcestershire was able to express his/her wishes regarding preferences and treatment at end of life. The End of life strategy (2008) acknowledged ACP as a priority and commissioned a countywide training programme. This is to enable collaborative countywide working and embedding the ACP documents in practice. Training and awareness will be provided for the workforce to enable understanding knowledge and skills required to support patients through ACP discussions.

**Conclusions**

There is limited evidence of the impact of ACP on outcomes. We conducted a retrospective cohort study on deaths of all patients known to a hospice in the last year of life in 2008. ACP is associated with a reduction in the number of days in hospital in the last year of life for those who completed ACP. 1.7 (p < 0.001). ACP completion reduces the mean number of days in hospital in the last year of life for those who died in hospital was 112.29 (p < 0.001). Mean number of emergency admissions for those who died in hospital was 2.2 and who died at home was 1.7 (p < 0.001). The new countywide ACP documents, this is seen as critical components of the quality improvement process in health and social care. A skilled workforce across health and social care will enable a consistent approach to advance care planning whereby patients and their families can express their wishes and preferences for end-of-life care. ACP supports high-quality, value-based care.

**Method**

A qualitative descriptive study was undertaken in three nursing homes implementing the GSFCH programme. Following an ACP discussion, semi-structured interviews were undertaken with 10 family members and 12 members of staff. Transcripts were used to identify the impact of ACP discussions; use of documentation; and, relationship and rapport.

**Objectives**

There is limited evidence of the impact of ACP on outcomes. We conducted a retrospective cohort study on deaths of all patients known to a hospice in the last year of life in 2008. ACP is associated with a reduction in the number of days in hospital in the last year of life for those who completed ACP. 1.7 (p < 0.001). ACP completion reduces the mean number of days in hospital in the last year of life for those who died in hospital was 112.29 (p < 0.001). Mean number of emergency admissions for those who died in hospital was 2.2 and who died at home was 1.7 (p < 0.001). The new countywide ACP documents, this is seen as critical components of the quality improvement process in health and social care. A skilled workforce across health and social care will enable a consistent approach to advance care planning whereby patients and their families can express their wishes and preferences for end-of-life care. ACP supports high-quality, value-based care.

**Results**

Families found comfort that their loved one’s future care had been considered. They felt reassured by the involvement of the family and staff in decisions. Residents were open to having ACP discussions, and were able to express wishes regarding preferences for their end-of-life care.

The assistance of a trained facilitator helped staff to develop the knowledge and skills required to deliver ACP discussions. The use of tick-box approaches was useful for prompts but limited the depth of their discussions with families and residents. The use of documentation either acted as a useful prompt or limited the discussion. Staff had to face their fears around discussing death and dying. The newly formed, three-component network for Worcestershire was able to express his/her wishes regarding preferences and treatment at end of life. The End of life strategy (2008) acknowledged ACP as a priority and commissioned a countywide training programme. This is to enable collaborative countywide working and embedding the ACP documents in practice. Training and awareness will be provided for the workforce to enable understanding knowledge and skills required to support patients through ACP discussions.

**Conclusions**

There is limited evidence of the impact of ACP on outcomes. We conducted a retrospective cohort study on deaths of all patients known to a hospice in the last year of life in 2008. ACP is associated with a reduction in the number of days in hospital in the last year of life for those who completed ACP. 1.7 (p < 0.001). ACP completion reduces the mean number of days in hospital in the last year of life for those who died in hospital was 112.29 (p < 0.001). Mean number of emergency admissions for those who died in hospital was 2.2 and who died at home was 1.7 (p < 0.001).