# B7: Developing soft skills in collaboration with patients

International Forum on
QUALITY & SAFETY
in HEALTHCARE
COPENHAGEN

# Adapting to a changing world: equity, sustainability and wellbeing for all

@QualityForum #Quality2023

Institute for Healthcare Improvement

BMJ

# Care at end of life in intensive care
# What matters to patients matters to staff !

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SCOTLAND

CLINICAL LEAD ORGAN DONATION NHSBT

SCOTTISH QUALITY AND SAFETY FELLOW COHORT 10

# Context


Inverness
Isle of Skye
Loch Ness
Aberdeen
Fort William
Isle of Mull
Scotland
St. Andrew
Edinburgh
Glasgow
Northern Ireland
England
100 km
Ireland
stepmap.com


WELCOME TO THE
ROYAL ALEXANDRA HOSPITA
MAX. HEADROOM 2.92m(9'7")

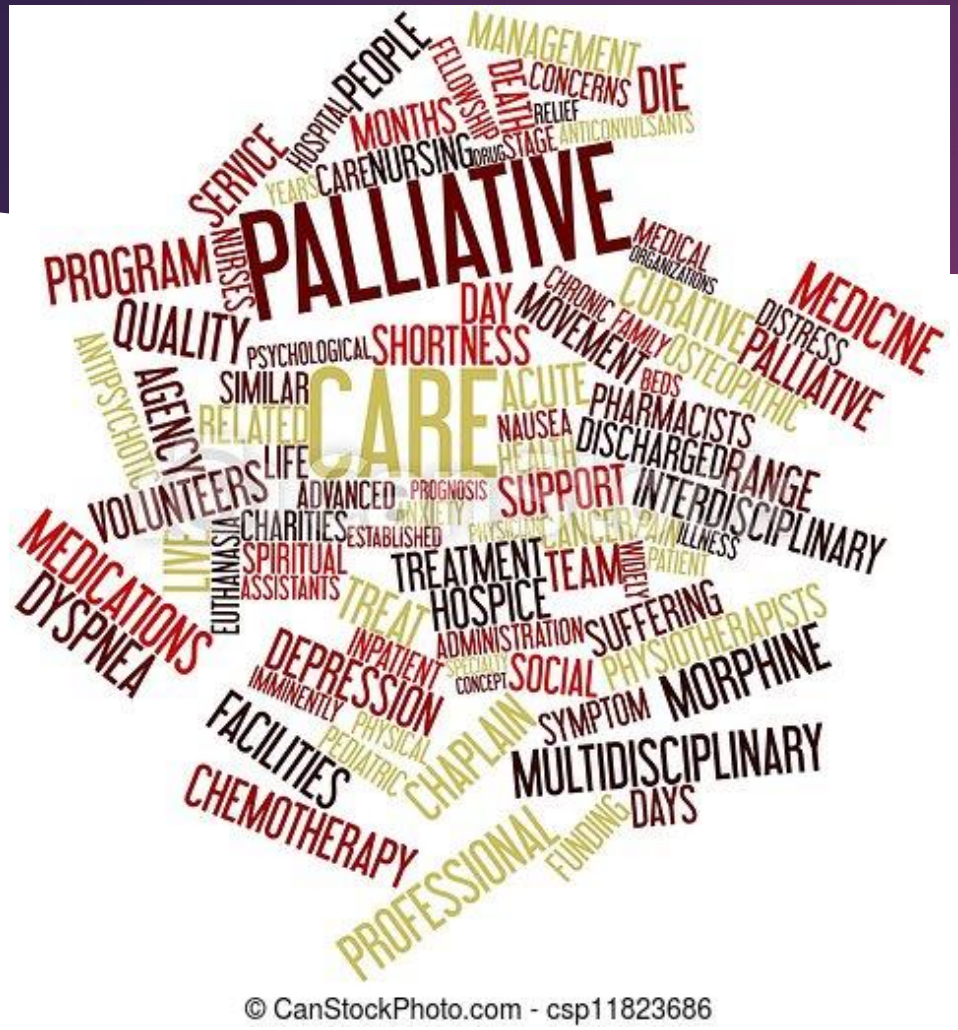
# Objectives

1. Use a reductive approach to a complex problem and identify modifiable and non modifiable factors

2 To engage all members of a team to collaborate to work towards a shared goal

3 .To use value based listening to improve care and peer support

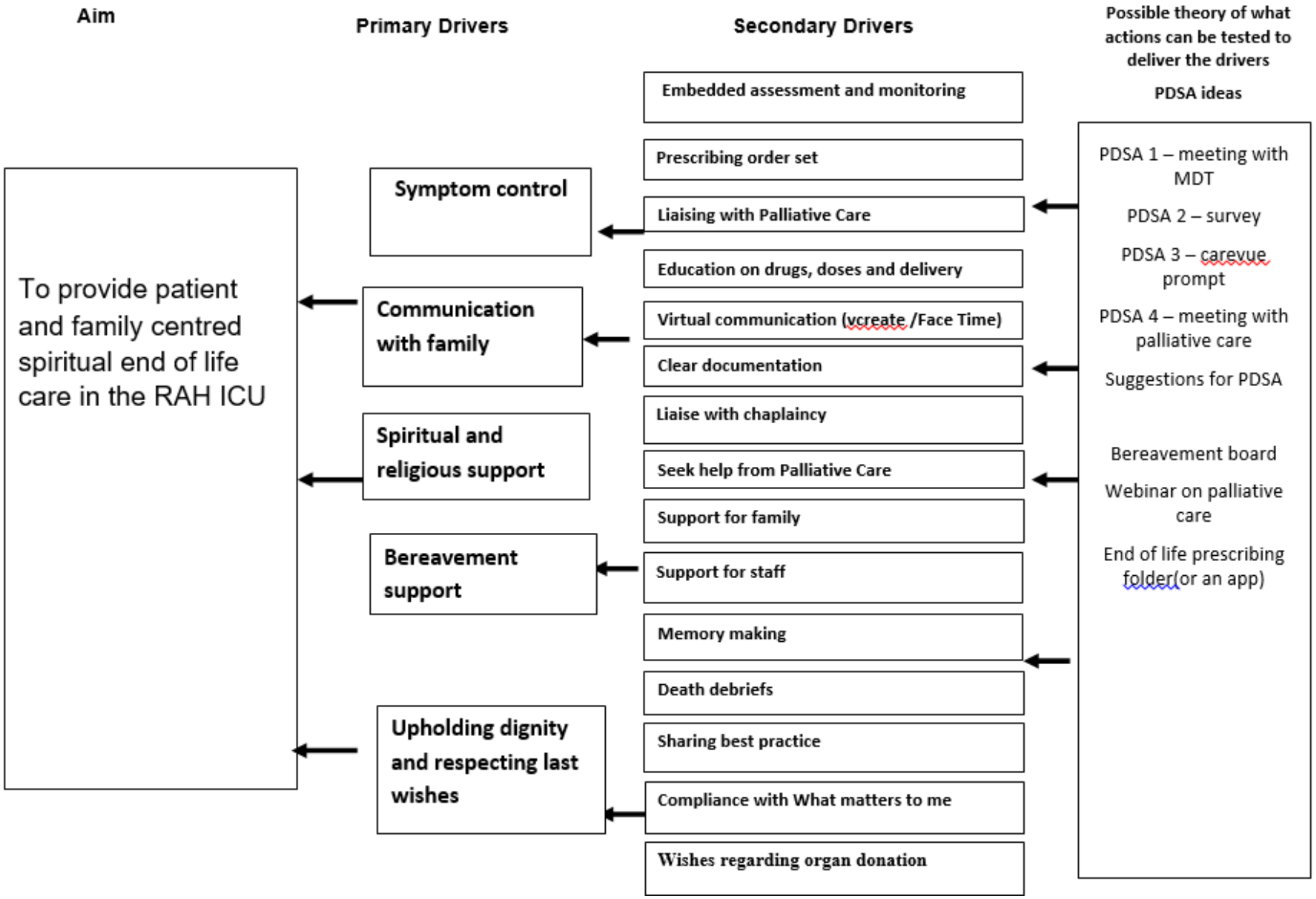
# Critical incident with prescribing at end of life- March 2020





- COMFORT
- DIGNITY
- SAFETY
- AUTONOMY

## Driver Diagram for improving EOL care in RAH ICU



# End of life prescribing

- 15-20% of our patients will die on the unit
- ‘A good death, as well as a good life, is important’
- Unclear at the RAH what the prescribing practices are
  - End of life tools being used?
  - What drugs are being used?
  - Inconsistencies across patients?
  - Prescribing should be symptom led – is it?

# What did we look at?

- Carevue End of life care plan initiated
- End of life prescribing bundle used?
- Routine and unnecessary medications stopped?
- Were patients maintained on their current sedation plan i.e. Alfentanil and propofol usually. Or were patients switched to Midazolam and Morphine?
- Briefly looked at levels of infusions used – would be easy to go back and assess further.

# General Carevue tools used and prescribing

## End of life care plan initiated?

Yes: 39 (95%)

No: 2 (5%)

## End of life prescribing bundle used?

Yes: 25 (61%)

No: 16 (39%)

## Other medications stopped?

Yes: 25 (61%)

No: 16 (39%)

# Specific prescribing

## Propofol stopped?

Yes: 20 (49%)

No: 19 (46%)

Yes but still on script: 2 (5%)

## Alfentanil stopped?

Yes: 25 (61%)

No: 16 (39%)

## Midaz/Morphine started?

Yes: 19 (46%)

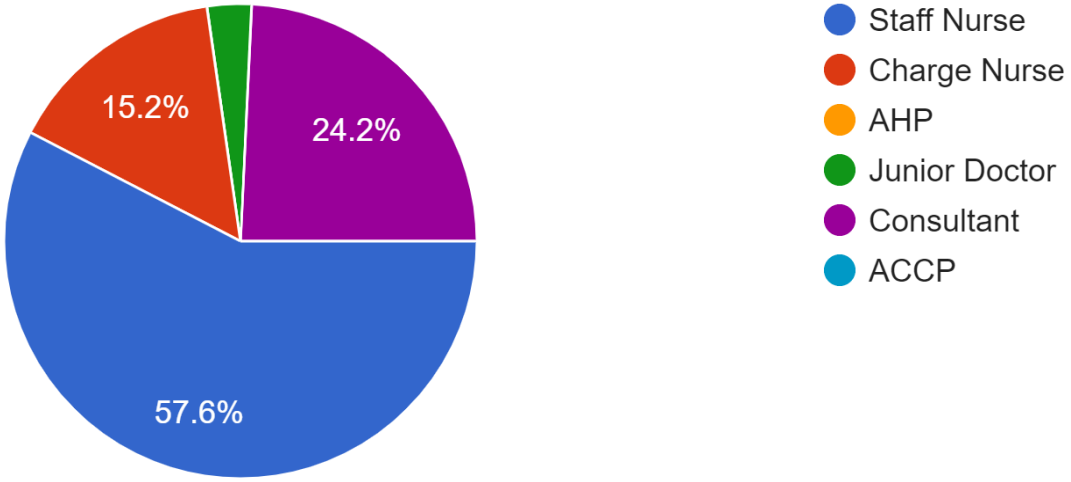
No: 17 (42%)

Prescribed not given: 5 (12%)

Morphine rate range 0.5mg/hr – 30mg/hr. Majority <5mg/hr

# Online questionnaire

- Sent to all MDT staff working in RAH ICU
- 33 respondents



# In your experience, do patients in our unit at the end of life experience a dignified death?

- Sometimes - 13
- All the time - 18
- Never - 0

Perhaps the most important question from the whole questionnaire. One of our primary aims should be achieving a dignified death for every one of our patients, and this shows we have a long way to go.

Are you aware there is an order set on Carevue for EOL prescribing?

- 9 respondents did not know there was an order set

In your experience, do find anticipatory medications prescribed for all end of life patients?

- Overwhelmingly staff felt anticipatory meds are only ‘sometimes’ prescribed.

Do you feel comfortable titrating medications to achieve comfort and analgesia for patients on EOL care?

- Yes 26
- No 7

# How do you think we should administer midazolam and morphine for patients on EOL care?

Wide variety of responses. General feeling is that it should not be prescriptive and it is patient and situation dependant, and all options should be available. Small trend towards syringe drivers.

| | **Staff Nurse** | **Charge Nurse** | **Consultant** |
|---|---|---|---|
| **Syringe driver** | 12 | 3 | 7 |
| **Continuous IV infusion** | 8 | 3 | 3 |
| **Bolus doses** | 2 | 1 | 3 |

# Are you confident using syringe drivers? Would you be interested in receiving training?

- 13 respondents confident in syringe driver use
- 19 respondents not confident in their use
- 28 respondents would be interested in receiving training
- When asked if any other drugs might be useful in EOL care 5 respondents mentioned an anti-emetic specifically Levomepromazine

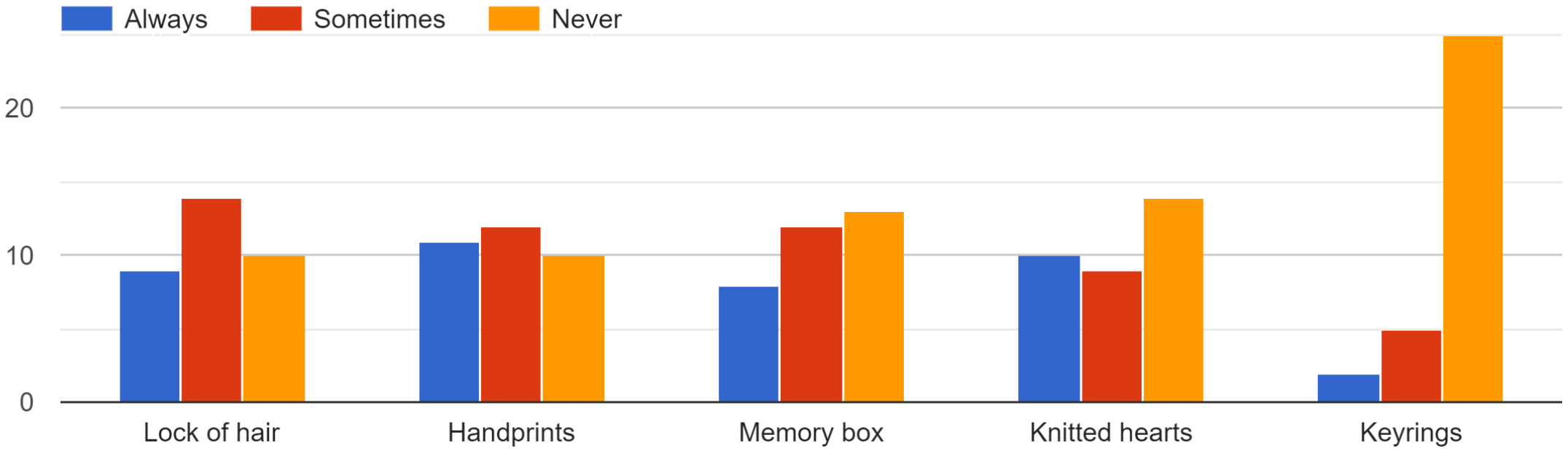
# Spiritual Care

Are you satisfied with the spiritual support we offer our families?

- Sometimes - 21
- All of the time - 10
- Never - 1

# Keepsakes

Do you ask families if they want



# Areas requested for more teaching/training

- Syringe drivers
- Conversion tables for drugs
- Clear guidelines and consensus surrounding prescribing
- Communication skills on delivering bad news/communicating with families surrounding death and dying
- Multiple comments about the desire to have teaching direct from palliative care specialists
- Spiritual care - availability and how to deliver it

# Staff bereavement support

- Obvious room for improvement in this area.
- Overall dissatisfaction with support offered and overwhelmingly respondents felt there isn't any support available or if there is, they did not know it existed or how to access it.

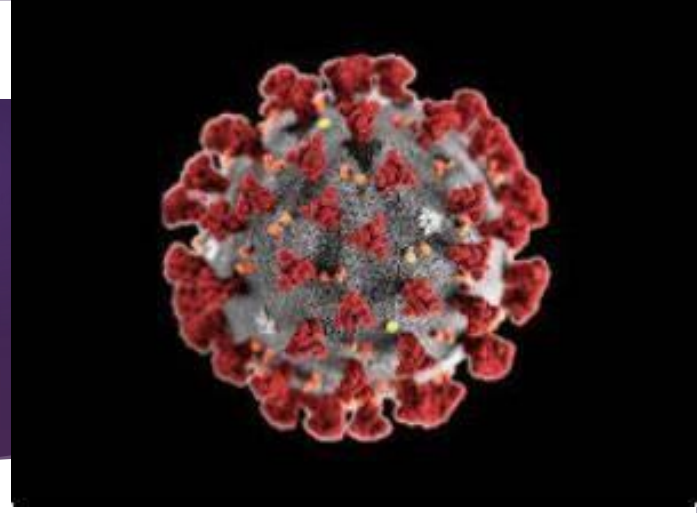
# What staff support do you find helpful at present?

- Lots of respondents stated there was none at present, or described it as ‘poor’
- Informal conversations with colleagues and informal peer support highlighted by respondents as main area of current support.
- Lack of debriefs highlighted as area for improvement
- “I feel the care for staff is somewhat over looked at times”

# Other suggestions from the questionnaire

- Greater consistency and standardising the approach to EOL
- Greater communication across the MDT, with shared decision making
- The use of debriefs highlighted multiple times
- Discussions about self care

# What emerged from this



Critical Incident
March 2020

Staff Survey
Nov 2020

Spiritual Lead walk arounds
March 2021

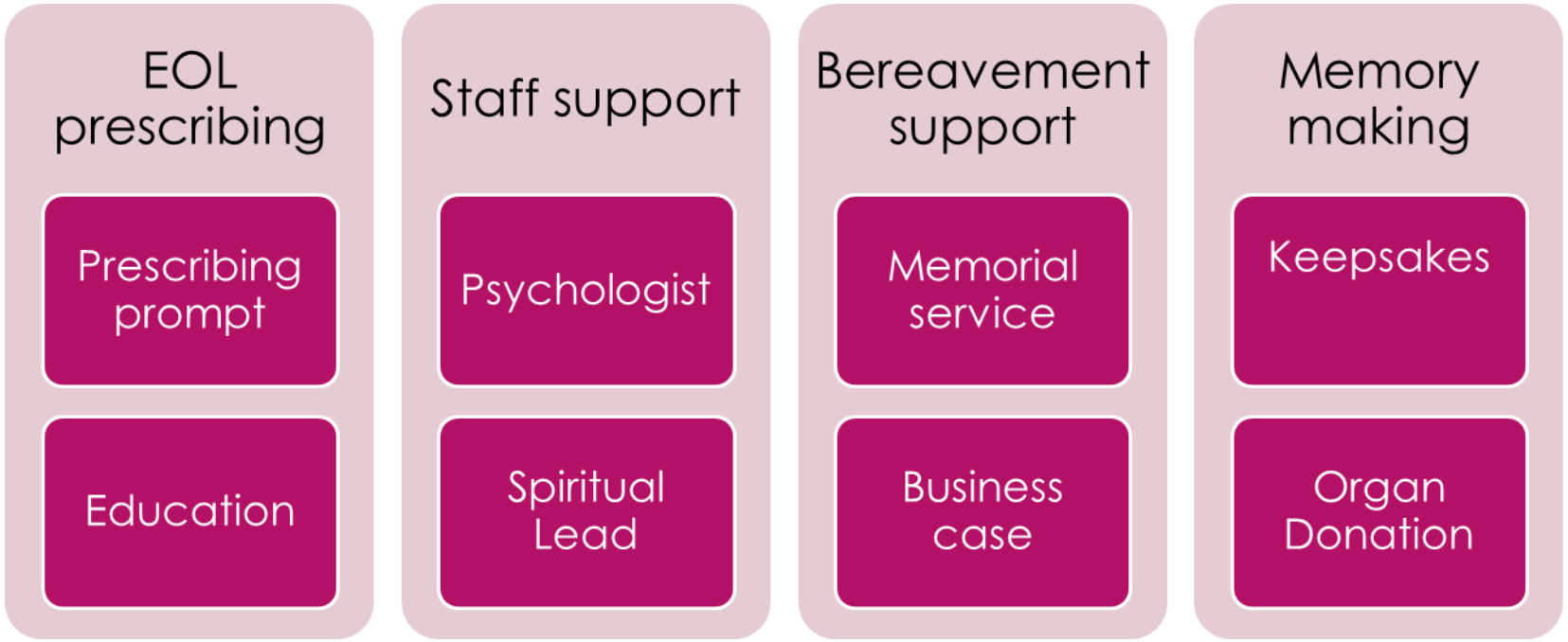
Death Debrief
First COMFRT and COFFEE
June 2021

EOL Prescribing audit
August 2020

Collaboration with Palliative Care
January 2021

Education from Palliative Care staff
June 2021

# We said – we listened – we made a change



# Humanising end of life care


- Ensure we know what matters to them
- Create memories for families
- Gift of life – approach every family about organ donation

# COMFRT tool

- C onsensus decision that focus of care needs to be changed
- O rgan donation considered
- M edical documentation
- F amily –space and time
- R eligious and Spiritual needs
- T asks – memory making , certificates and personal belongings

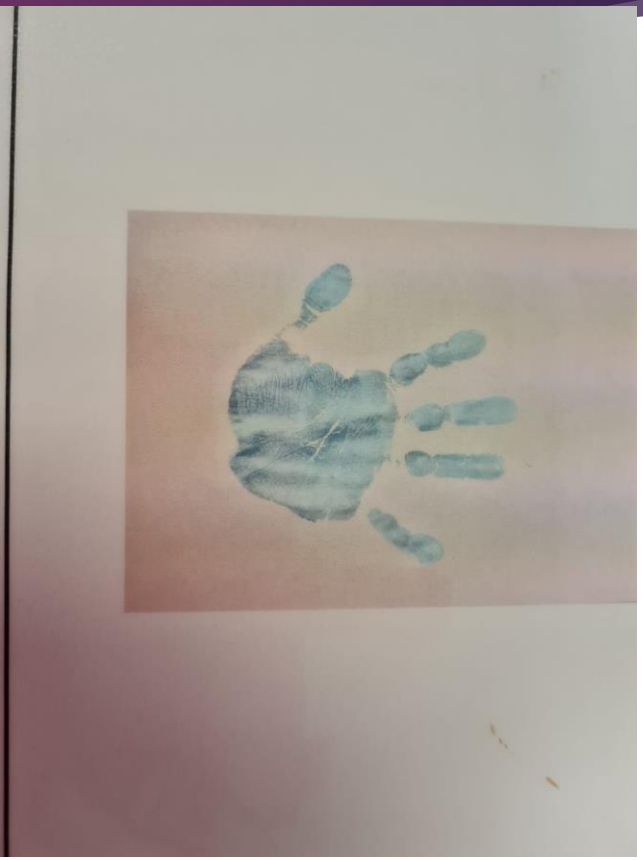

The Order Of St John award presented to families at an annual ceremony held in all 12 regions within the UK


The gold Heart pins that are given to our donor families to honour their loved one

The finger print family trees that we offer to our donor families

The heart beat in a bottle we give our donor families if they wish

# Teddies and handprints

# We Remember: A Critical Care Covid 19 Remembrance Service

*Dr Ross Norris, Dr Jacqueline McCarthy, Dr David Gray & Dr Radha Sundaram*
*Royal Alexandra Hospital, NHS Greater Glasgow and Clyde*

## Background

There is increasing recognition that palliative care when provided appropriately to critically ill patients with life limiting illness can not only offer physical, psychosocial and spiritual care to patients but also helps improve family and staff satisfaction. This recognition and direct feedback from staff led to the establishment of a multi-disciplinary palliative care quality improvement group within the critical care department at the Royal Alexandra Hospital in Paisley.

An initial staff survey was distributed within the unit to identify areas for improvement. The feedback showed spiritual and bereavement support as key areas for improvement.

Based on this feedback, the decision was made to host a remembrance service for the loved ones of patients who had passed away in the unit over the

## The Service

The service was planned by the multi-disciplinary palliative care quality improvement group. Funding to host the service was obtained from the charity To Absent Friends.

The critical care database, Ward Watcher was utilised to identify all patients who had passed away in the unit over the course of the pandemic. Importantly this included those who had passed as a direct consequence of COVID and those who had not. The total number was 237.

The families and loved ones of each patient were invited.

A non-denominational service consisting of readings, live music and acts of remembrance was held within the hospital grounds. It was attended by over 13 member of staff and over 40 families

## Feedback

Feedback was obtained from both staff and families who attended.

Staff who attended were asked to complete an online feedback form.

69% of those who attended completed the feedback and rated the service to be successful (0 being very unsuccessful and 10 being very successful)


The majority (89%) reported that it brought them comfort.


Formal feedback from families and loved ones who attended was limited. However, anecdotal feedback was positive. Examples include:

***"Heartfelt thanks to all for the service which gave me the 'closure' I did not get in 2020 with a COVID limited funeral"***

***"It was a lovely, albeit emotional, service which gave a lot of comfort to myself and my daughter"***

## Conclusions

Although the feedback received was limited, both formal and anecdotal feedback from attendees suggests a remembrance service can be of benefit to both families and staff, particularly in the context of a pandemic when visiting was curtailed.

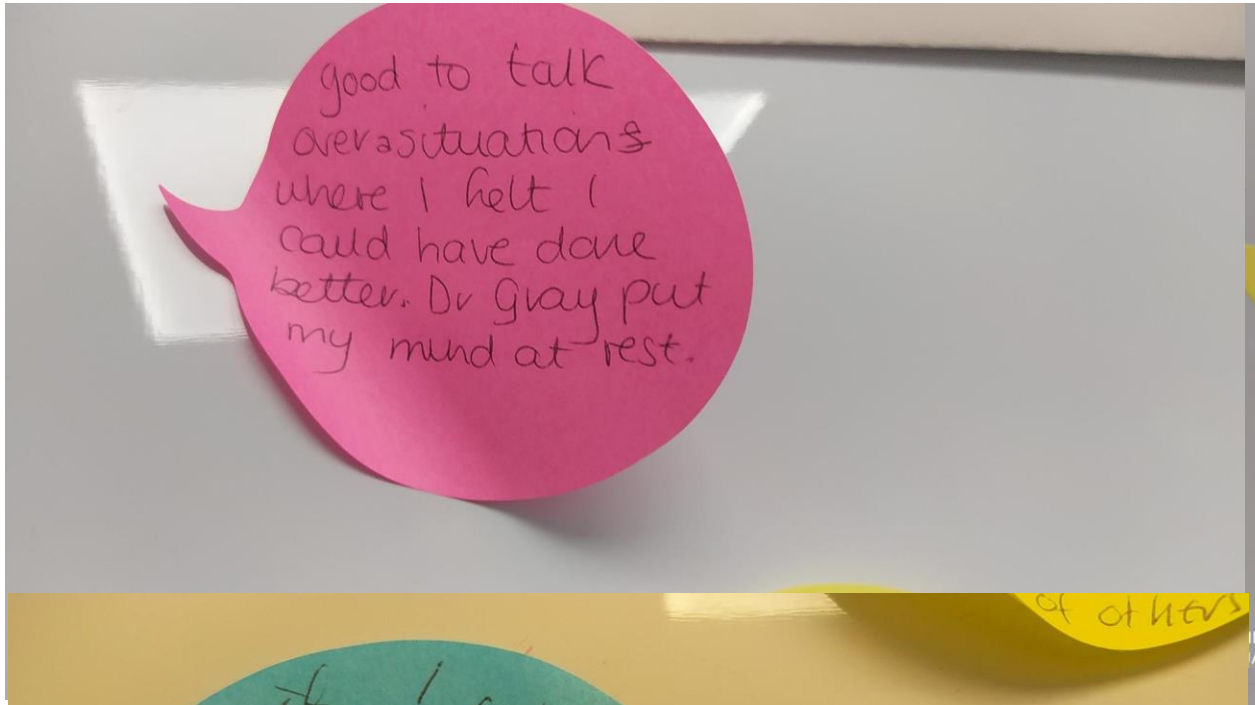
# What matters to families

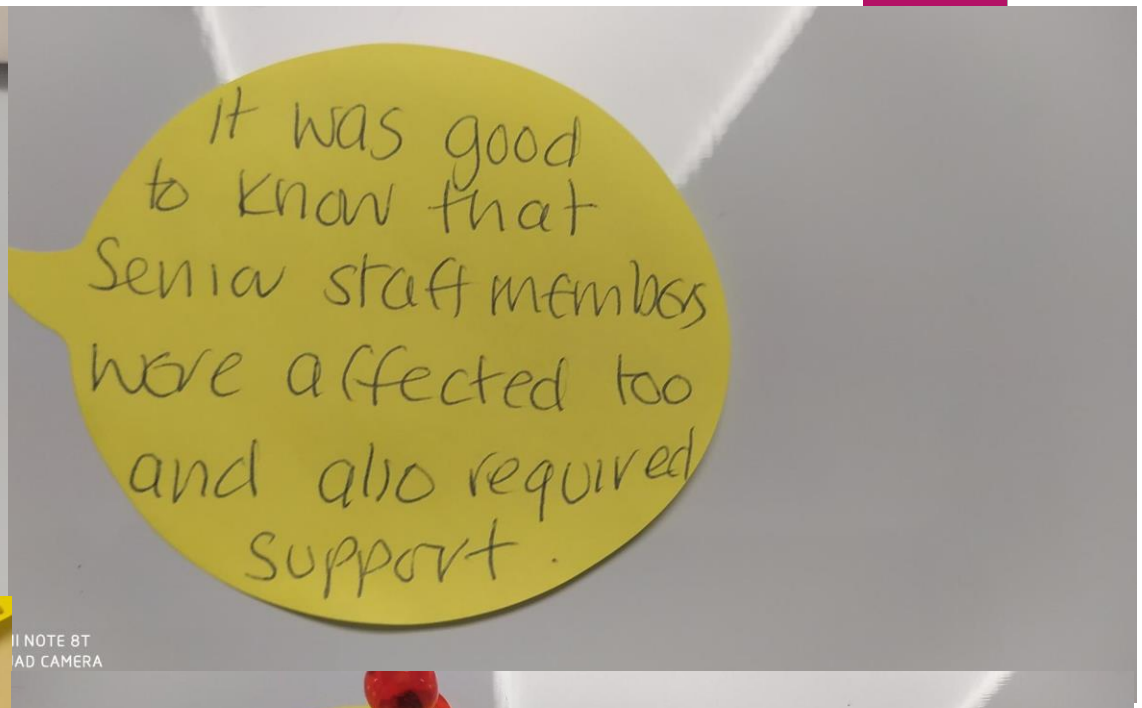
The lovely remembranc e service helped my daughters and I as it went some way to replacing the service she did not have.

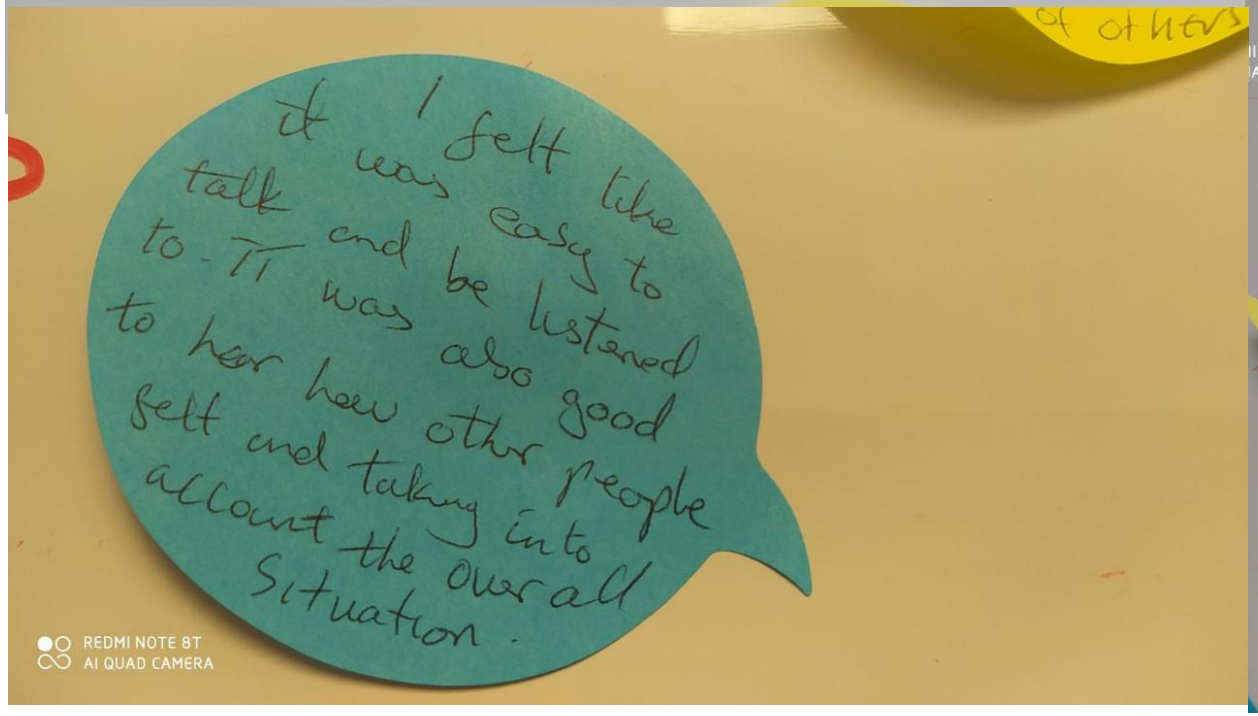
I just wanted to say thank you very much to everyone involved in arranging Saturday's Service of Remembrance.  It was a lovely, albeit emotional, service which gave a lot of comfort to myself and my daughter. Then to sit and speak with other families whilst enjoying the delicious home-baking was the perfect way to end the morning.

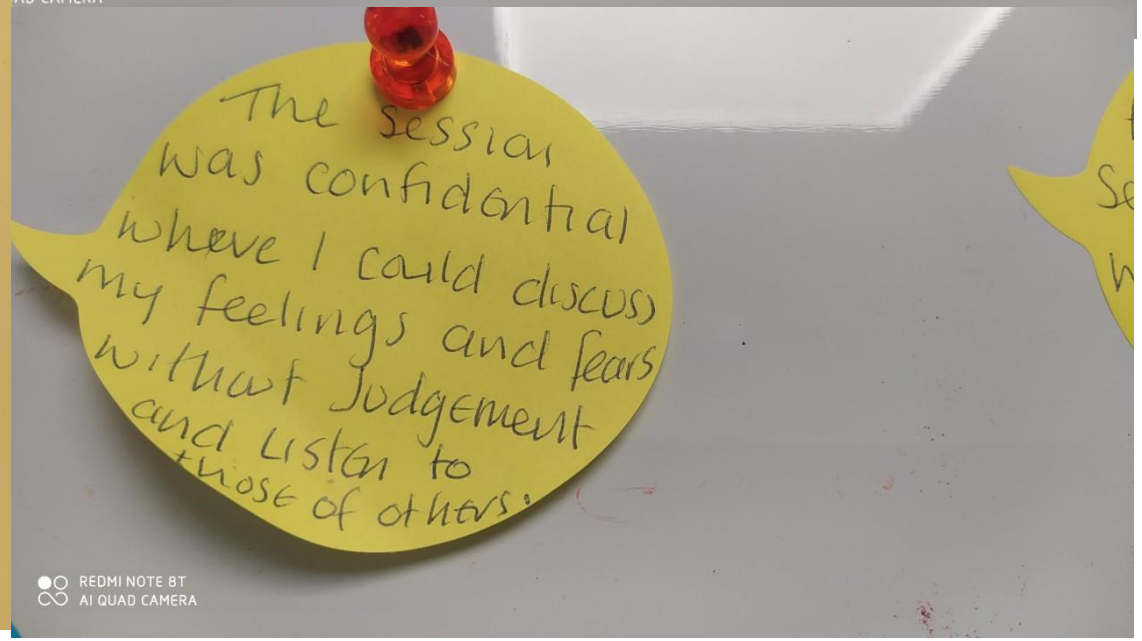
Thank you for the lovely Remembrance Service. Everything was perfect and so fitting. My husband  would have loved it too. Thank you to everybody for looking after him and my family are forever grateful to all the staff in those hard and difficult times.

# A sanctuary – HALO gardens and a buddy chair

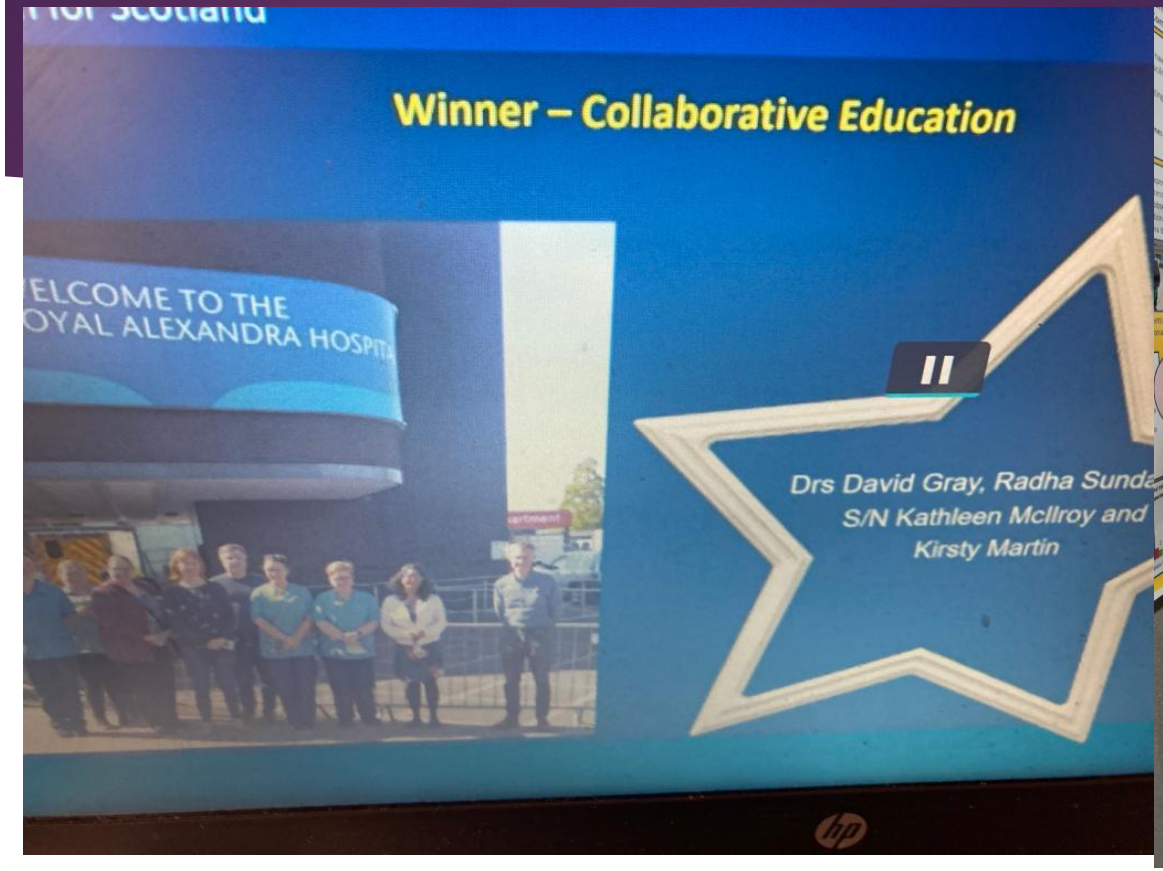

good to talk over situations where I felt I could have done better. Dr Gray put my mind at rest.


It was good to know that Senior staff members were affected too and also required support.


It I felt like it was easy to talk and be listened to. It was also good to hear how other people felt and taking into account the overall situation.
REDMI NOTE 8T
AI QUAD CAMERA


The session was confidential where I could discuss my feelings and fears without judgement and listen to those of others.
REDMI NOTE 8T
AI QUAD CAMERA


10:07
Tweet
To Absent Friends
@2AbsentFriends
The End of Life Quality Improvement Group, Critical Care, at the Royal Alexandria Hospital in Paisley work so hard, and they're still putting on a memorial event for #ToAbsentFriends on November 26 @nhsggc: toabsentfriends.org.uk/news/festival-...
11:47 · 03 Nov 22 · Twitter Web App
4 Retweets 6 Likes
Tweet your reply


Winner – Collaborative Education
ELCOME TO THE
OYAL ALEXANDRA HOSPITA
Drs David Gray, Radha Sunda
S/N Kathleen McIlroy and
Kirsty Martin


Improving end of life care in critical care – why everyone matters
A quality improvement project to improve end of life care in a critical care unit at the RAH
NHS
BACKGROUND
LESSONS LEARNT
REFERENCES

# Service Evaluation

| | |
|---|---|
| EOL Prescribing | Increased from 61% (2020) to 79% in 2022 |
| Coffee and COMFRT | Three meetings a year since 2021 ; last meeting attended by 20 staff members |
| Keepsakes | Offered to every family at EOL |
| Organ Donation | Referrals have increased from 10 ( 2018) to 29 (2022) and donations from 2 to 6 |
| Palliative care involvement | No data but sense that referrals are more frequent |
| Staff engagement | QI group has expanded from 5 members to 15 |
| Professional Development | Three abstracts – two for doctors in training and one for nurses , two national meeting , one journal article in progress, |

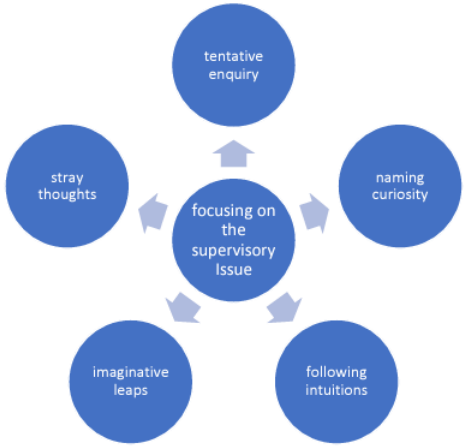
# Value Based Reflective Practice (VBRP)

- VBRP® promotes person-centred care
- It engages in dialogue between personal and organisational values, attitudes and behaviours.
- It enhances staff fulfilment and turns history (what we have done) into learning.
- It supports staff members to better manage their own wellbeing and resilience, and helps them to develop increased reflexivity in their practice.
- The goal is to improve the care provided to patients and service users.
- Our spiritual leads (chaplains ) are trained in it and now participate in Coffee and COMFRT debriefs and clinical Multi disciplinary meetings

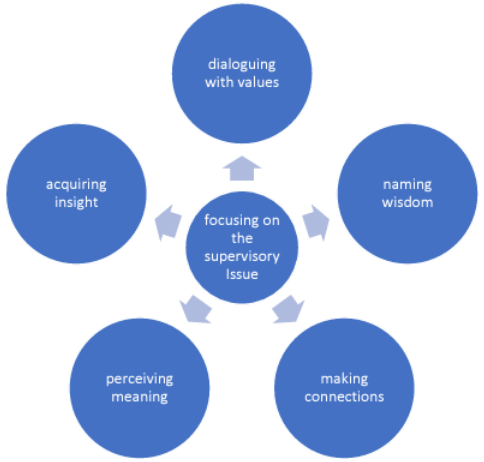
# VBRP®

1st Level of Seeing – Seeing & Noticing


2nd Level of Seeing – Wondering & Musing




3rd Level of Seeing – Perceiving & Realising



# Evidence vs real world

| Element |
|---|
| Nonabandonment[4-6] |
| Committed, quality connection |
| Ongoing support |
| Taking an interest in the patient as a person[7-9] |
| Enhance empathy, respect, connectedness |
| Affirm worth of who they are, were, or tried to be and what they achieved or tried to accomplish |
| Holding/containing hope[10-15] |
| Finding hope for psychological, spiritual, and physical comfort |
| Hope for minimal suffering and a peaceful death |
| Finding meaning and purpose in |
| Relationships |
| Imparting words/sentiments that need to be shared, such as reconciliation, forgiveness, love, affirmation of feelings |
| Modeling how to die |
| Guiding families toward viable opportunities[15] |
| Time |
| Connection |
| Comfort |
| Forgiveness |
| Goodbyes |
| Dignity affirming tone of care/Therpeutic Presence[16] |
| Being compassionate and empathic |
| Being respectful and nonjudgmental |
| Being genuine and authentic |
| Being trustworthy |
| Being fully present |
| Valuing intrinsic worth of the patient |
| Being mindful of boundaries and being emotionally resilient |
| Therapeutic humility[16] |
| Tolerate clinical ambiguity |
| Accept and honor the patient's expertise |
| Trust in the process |
| Avoid the need to fix |

# Acknowledgements

EOL QI team at RAH

Prof Kevin Rooney Clinical Director

Dr David Gray Consultant in Palliative Care

To absent friends – Scottish charity

Aileen Labram Specialist Nurse in Organ Donation

# References


- 1. Values based reflective practice (VBRP®) | Turas | Learn (nhs.scot)
- 2. Intensive Caring: Reminding Patients They Matter - PubMed (nih.gov)
- 3. Care at the End of Life | The Faculty of Intensive Care Medicine (ficm.ac.uk)
- 4.Palliative care in intensive care units: why, where, what, who, when, how | BMC Anesthesiology | Full Text (biomedcentral.com)

# Questions

You matter because you are you

and you matter to the

last moment of your life

Radha.Sundaram@ggc.scot.nhs.uk

# Building capacity
# - to understand the patient and yourself

Christina Fogtmann, Professor , Københavns Universitet
Charlotte Verner Rossing, Director Research and Development,
Pharmakon, Danish College of Pharmacy Practice

Pharmakon

UNIVERSITY OF COPENHAGEN

eit Health

EIT Health is supported by the EIT, a body of the European Union

# Pharmaceutical care

”The responsable provision of drug terapi for the purpose of achieving definite outcomes which improve the patient’s quality of life.”

Hepler og Strand 1990

## Kierkegaard

*If One Is Truly to Succeed in Leading a person to a Specific Place,*

*One must First and Foremost Take Care to Find Him Where He Is and Begin There*

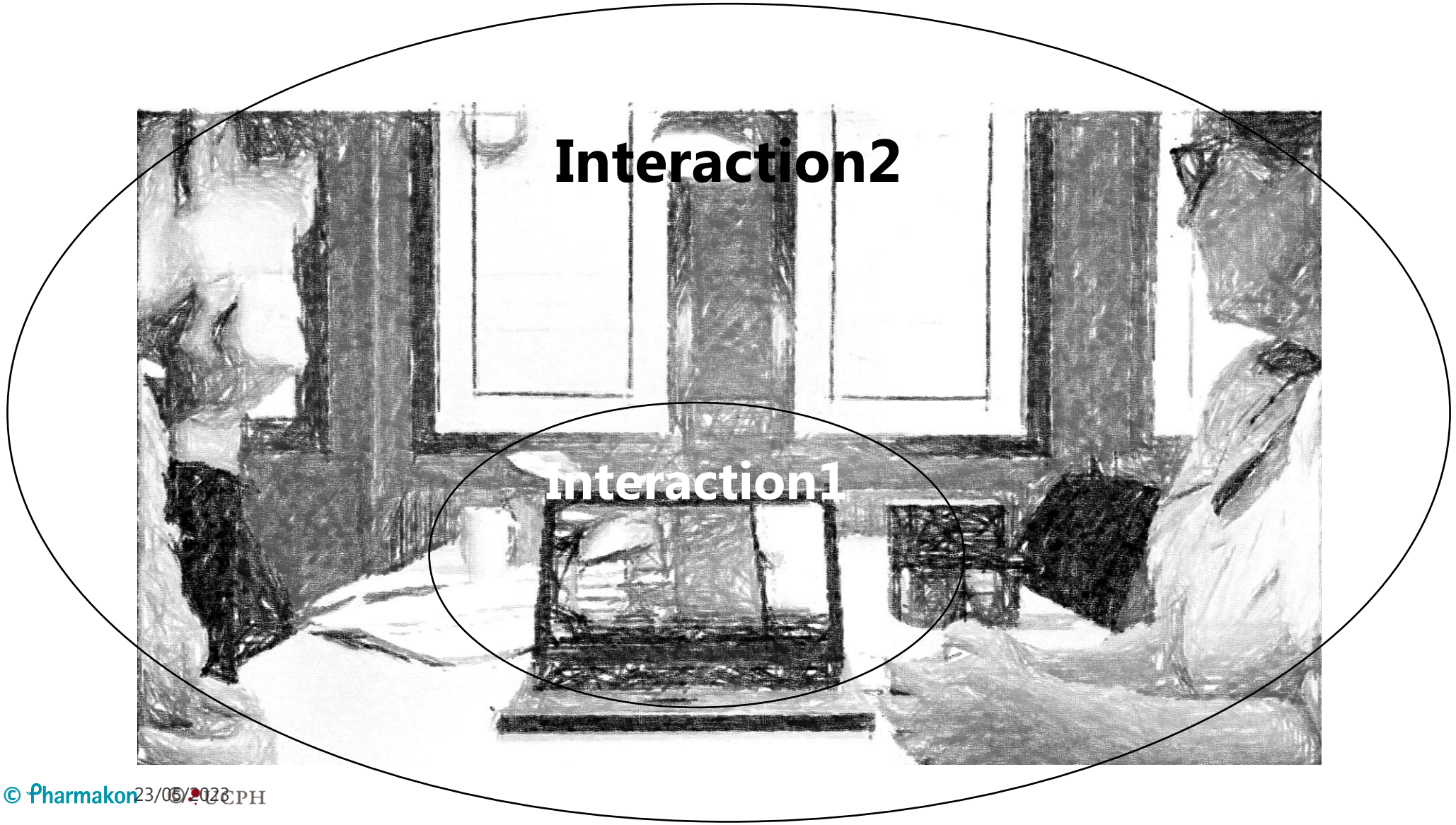
# Patient-centered communication

To establish patient-centered communication patients need to engage their first person perspective

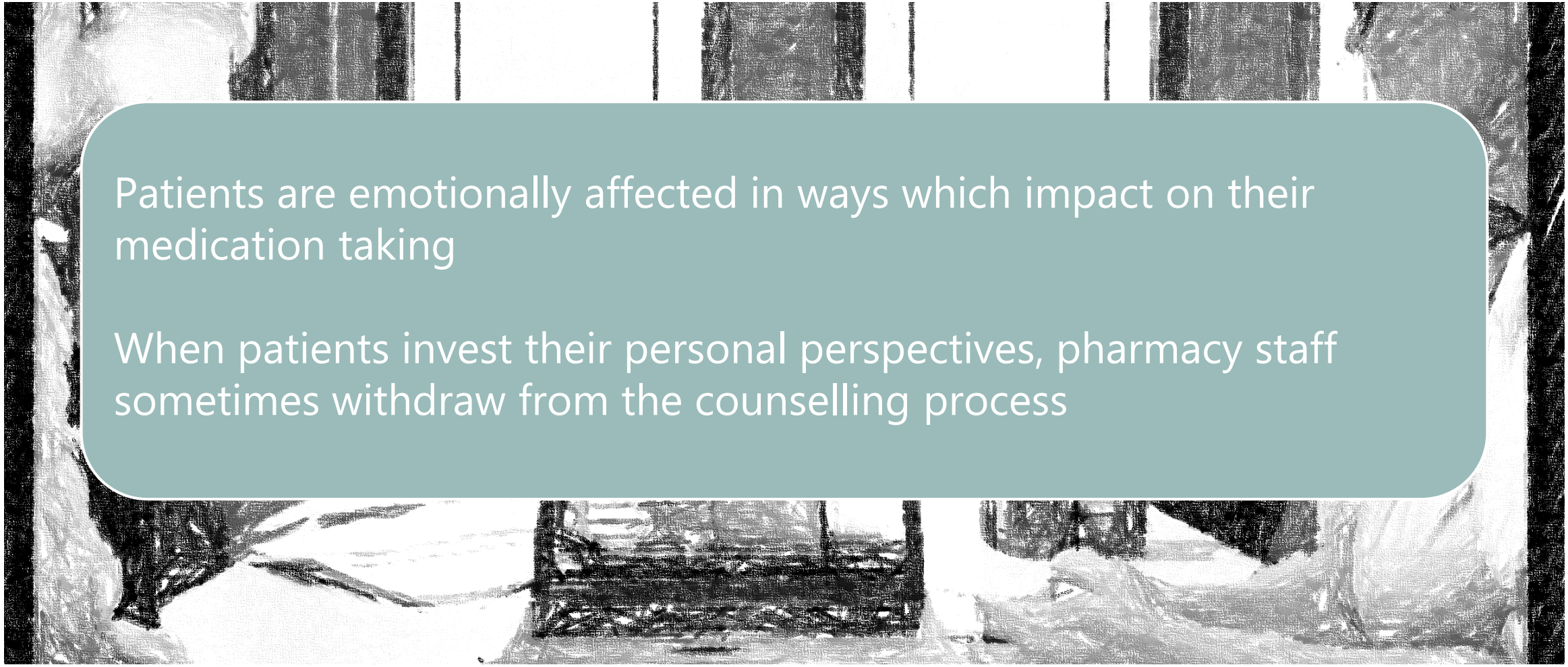
**An important task of health care professionals:**
Relationship building wherein patients experience a genuine interest and curiosity

- Invite patients to engage their perspective - Responsiveness toward these perspectives
*A skill that needs to be professionalized*
This calls for staff to be inclined to understand the patient

# Video-stimulated recall interview



# Findings based on video-stimulated interviews



Patients are emotionally affected in ways which impact on their medication taking

When patients invest their personal perspectives, pharmacy staff sometimes withdraw from the counselling process

# What is mentalization?

- An activity involved with trying to understand the mental states connected to our own and others' behavior
  Mental states: thoughts, feelings, needs, intentions

- Meeting others as unique individuals
  With acceptance, interest and peace of mind

- Double-perspective
  Mentalizing entails understanding both the other and understanding oneself

- Everyone is capable of mentalizing, but to varying degrees
  The ability can be trained



Allen, J.G. (2006). Mentalising in Practice. In J. G. Allen & P. Fonagy (Eds.), Handbook of Mentalisation-Based Treatment (pp. 1–30). John Wiley & Sons, Ltd

# If the mentalizing ability is trained

- Attention to and understanding of customer reactions increases

- Attention to oneself , one's own reactions and barriers in customer meetings increases

Consequence: customers can be helped with their specific questions and challenges regarding their medicine

Fosgerau, C., Clemmensen, N. B., Husted, G. R., Kaae, S., & Rossing, C. (2022). PROGRAMME DESCRIPTION: A mentalising education programme for community pharmacy workforce. *Pharmacy Education, 22*(1), 77-87.

Mentalization has not previously been incorporated into pharmacy

But the tendency is apparent in other domains of healthcare interactions

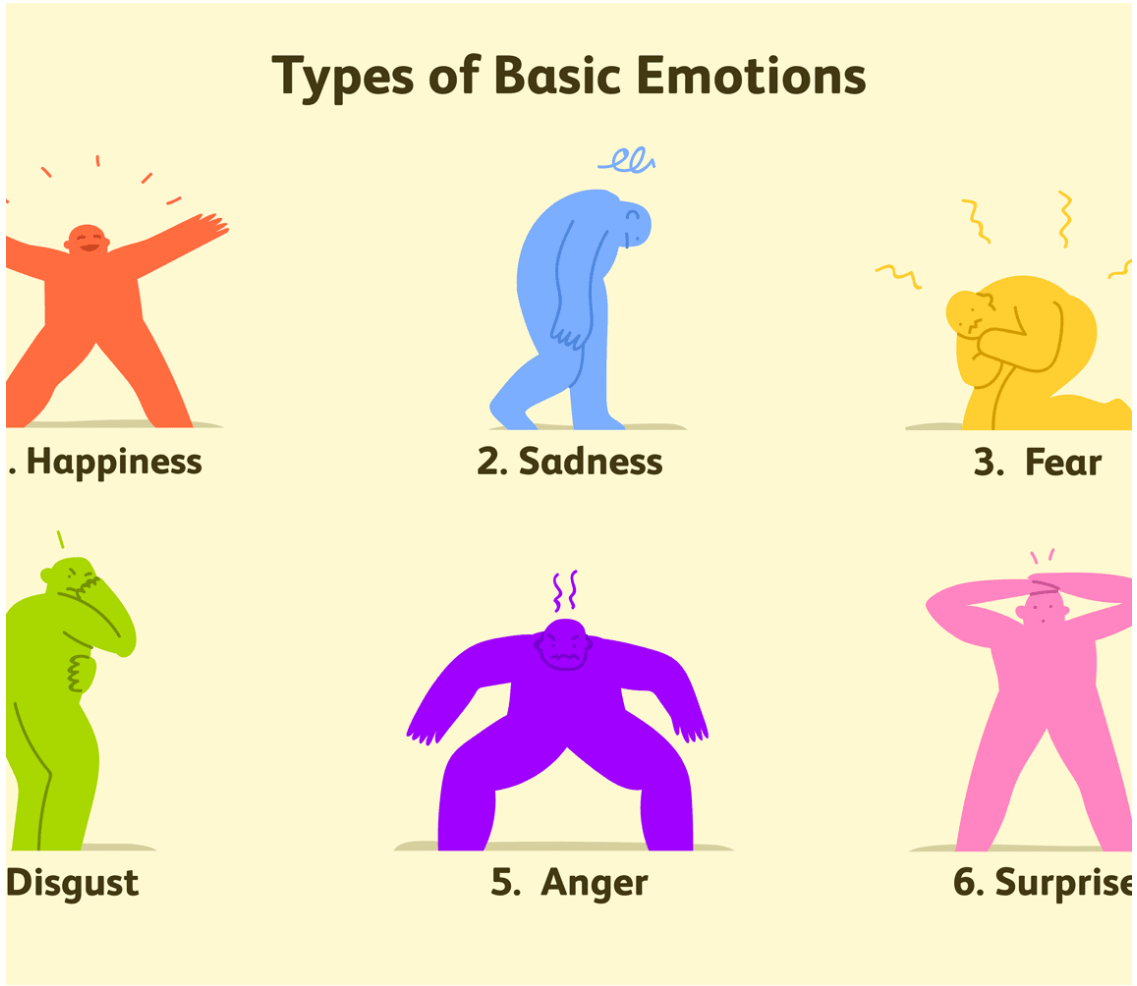
# Emotions

Originating in the body

Emotions add value to our experiences

Affect how we act in the world

We are always in an emotional state



# MENTALIZING AND EMOTIONAL AWARENESS

Emotional awareness:

The ability to identify and name other people's and own emotions

Central to emotional awareness is the ability to regulate emotions

# Counselling first hand - Understanding the patient and yourself through mentalizing

Tested in 2021

Pharmakon

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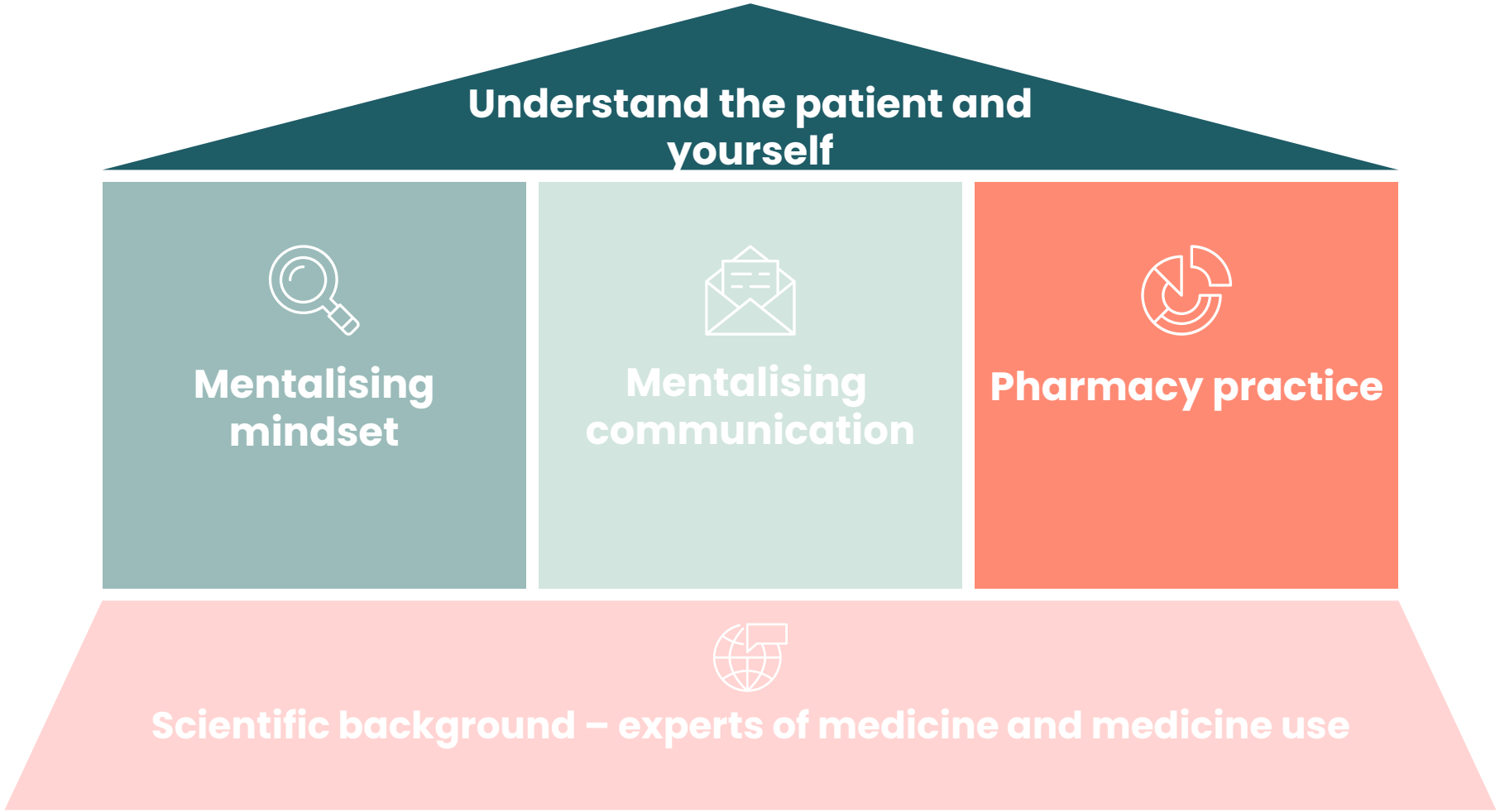
EIT Health is supported by the EIT, a body of the European Union



# Two perceptions of pharmacy counselling

| The scientific perception | The humanistic perception |
|---|---|
| Evidence-based, quality-controlled practice | Empowerment of the patient |
| Medical starting point | Starting point in everyday life |
| Expert role | Discussion partner |
| Objective (value neutral) | Personal, subjective (with values) |
| Focus on symptoms, medicine-related problems and lifestyle issues | Focus on the patient's experiences, wishes, beliefs, feelings and circumstances |
| Identifying risks, errors and problems | Identifying resources |
| Giving correct advice and recommending the right treatment | Tailor making solutions |
| Network involves a risk of noise and mistakes | Network is an important resource |
| The professional is in charge | The patient is in charge |


- Classroom teaching
- Online teaching
- A new competence
  - Knowledge
  - Exercises
- Individual feedback
- Home assignments
- Final assignment

*Pharmacy Education* (2022) 22(1) 77 - 87
https://doi.org/10.46542/pe.2022.221.7787

PROGRAMME DESCRIPTION

# A mentalising education programme for community pharmacy workforce

Christina Fosgerau[1], Nanna Broch Clemmensen[1], Gitte Reventlov Husted[2], Susanne Kaae[1], Charlotte Rossing[2]

[1] University of Copenhagen, Denmark

[2] Research and Development, Pharmakon - Danish College of Pharmacy Practice, Denmark

WEEK 0

PREPARATION

Prior to module 1, participants must:
- Complete the MentS, LEAS and RME questionnaires
- Record three-five counter meetings
- Watch film explaining the content and structure of the education

MODULE 1
(Physical attendance)
- Welcome
- Counseling at the pharmacy
- Introduction to mentalising and the mentalising mindset
- The affective-cognitive dimension
- Visit from patients
- The meeting with the pharmacy-customer

LEARNING OUTCOMES:
Knowledge about:
- standards for counseling at the pharmacy, past and present
- the mentalising capacity –what it entails and why it is relevant in a community pharmacy practice
- the importance of emotions in relation to behavior
- life as a patient with chronic illness
- the value of adopting a new approach to the community pharmacy encounter

Competencies in:
- mentalising communication with a focus on the self-other dimension in a pharmacy context

WEEK 1

WEEK 2

PREPARATION

Prior to module 2, participants must select which recording they would like to receive feedback on

MODULE 2
(Online attendance)

- The self-other dimension
- Mentalising communication
- Individual feedback

LEARNING OUTCOMES:
Knowledge about:
- the development of the capacity to mentalise, and subsequently own conditions for having acquired the capacity
- interpersonal differences in perspectives
- how the mentalising mindset is expressed through mentalising communication
- the self-other dimension of mentalising
- own communication tendencies and mentalising capacity

Competencies in:
- mentalizing communication with a focus on the self-other dimension in a pharmacy context

WEEK 3

PREPARATION

Prior to module 3, participants must complete a writing exercise ("What was it like to be you")

WEEK 4

WEEK 5

MODULE 3
(Online attendance)

- How customers view the pharmacy
- Epistemic trust
- The implicit-explicit dimension

LEARNING OUTCOMES:
Knowledge about:
- *epistemic trust* as central for the transmission of knowledge sharing in interactions
- how customers perceive the pharmacy
- the implicit-explicit dimension of mentalizing

Competencies in:
- mentalising communication with a focus on the implicit-explicit dimension in a pharmacy context

PREPARATION

Prior to module 4, participants must document two counter meetings where they practiced mirroring, active listening, and posing open questions

WEEK 6

WEEK 7

MODULE 4
(Online attendance)

- What affects your ability to mentalise
- Mentalising communication

LEARNING OUTCOMES:
Knowledge about:
- the context dependency of the capacity to mentalise; how it varies according to intra- and interpersonal contextual factors

Competencies in:
- Expressing the mentalising mindset through mentalising communication and with a continued focus on the dimensions self-other, affective-cognitive, implicit-explicit and on epistemic trust in customer counseling

PREPARATION

Prior to module 5, participants must

PREPARATION

Prior to module 5, participants must complete a written exercise ("complete the following sentences")

communication and with a continued focus on the dimensions self-other, affective-cognitive, implicit-explicit and on epistemic trust in customer counseling

WEEK 8

MODULE 5
(Physical attendance)

- Exercises

WEEK 9

LEARNING OUTCOMES:
Knowledge about:
- how to enhance and connect the theoretical aspects related to the mentalising mindset with mentalizing communication in relevant communication scenarios

Competencies in:
- Expressing the mentalising mindset through mentalising communication and with a continued focus on the dimensions self-other, affective-cognitive, implicit-explicit and on epistemic trust in customer counseling

PREPARATION

Prior to module 6, participants must record three to five counter meetings, and choose one to receive feedback on

WEEK

MODULE 6
(Online attendance)
- Repetition of key concepts
- Individual feedback

WEEK

LEARNING OUTCOMES:
Knowledge about:
- own communication tendencies and development in mentalising capacity

Competencies in:
- Reflecting on own mentalising potentials and barriers in the pharmacy context

FINAL REPORT

The concluding effort of the education programme is for the participants to produce a written report regarding their gained outcome of the education. The report consists of 32 questions each targeting an aspect of the educational content – either gauging their theoretical understanding and knowledge or their acquired skills in mentalizing communication. The report is to be completed individually and is graded by the teachers of the continuing education programme.

# – Promising results from the evaluation of an education programme for pharmacy workforce to support patient-centred counselling.

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# Purpose of the evaluation

- to evaluate participants' knowledge of mentalizing in a community pharmacy practice context and their skills and benefits of transferring this to knowledge about how to act and communicate in mentalizing ways in pharmacy encounters, with the potential of establishing patient-centred counselling.

# Quantitative results

- a significant increase in awareness of mental states ($p<0,001$),
- a significant improvement of job satisfaction regarding salary ($p = 0.01$), prospects ($p= 0.04$) and standards of care ($p= 0,004$),
- that most participants agreed (47.8%) and strongly agreed (39.1%) that they were satisfied with the education programme.

# Qualitative results

Three themes

1) “Awareness of emotions and communication skills is an important element when mentalizing is the goal”,
2) “It’s far more than just a dispensing situation – I now tune into the patient”
3) “Don’t have to hide behind the screen any longer”.

# In conclusion

*"Every day, I try to meet all patients with interest, serenity and acceptance. That's given me a lot of eye-opening experiences and many more positive and successful counselling situations – situations where I believe I've made a difference for the patient – for the sake of the patient – and where I've also had a positive experience of the interaction with the patient myself. It's become much more than a dispensing situation."*

*"My awareness of the patient has been strengthened. I'm much more aware of signals from the patients who express their emotions verbally and non-verbally. At the same time, I've become aware of my own emotions, thoughts, needs and intentions. I know now that I have to be able to embrace the patients' emotions and thoughts as well as my own."*

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