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SUMMARY

The 4Cs Project (Courageous, Compassionate, Confident Conversations) was designed and driven by a multidisciplinary team of staff caring for patients with frailty in a community hospital setting at Worcester City In Patient Unit. They had realised that frailty was frequently underdiagnosed and that these patients were often reaching the end of life without its recognition and the necessary conversations about advance care planning taking place with them and their families was being missed. The key to the project's success was to focus first on the staff and their concerns, as well as their lack of confidence around discussing death and dying. They designed initiatives together that addressed their hesitance, and in turn strengthened their team and community, and created "Joy in Work".

Key Words

Frailty; conversations; advance care planning; community; joy in work

INTRODUCTION

During 2017, Worcester City In Patient Unit underwent a large change management process that required all staff to be focused on implementing changes. With this change in management process, little time was allocated to focus on other important aspects of the hospital's functions. In our community hospital environment, we realised that frailty was not being routinely diagnosed, or recognised, as an end-of-life state and that, as a consequence, advance care planning discussions were not available to patients. There is no single generally accepted clinical definition of frailty.¹ We used our Clinical Lead on Frailty, Dr Maggie Keeble's, own definition: "A long-term condition, associated with, but not directly related to age, causing a global deterioration of function and leading to reduced ability to withstand illness, resulting in the potential for sudden deterioration." We aimed to bring the principles of good communication and advance care planning associated with palliative care to the patients in our non-specialist community hospital who are living with frailty.

SUMMARY

Given that advance care discussions around frailty were not taking place, we saw an opportunity as a multidisciplinary team (MDT) to collaborate on a *creative* project the whole team considered important and found inspirational. In this project, we set out to:

1. Increase staff's awareness of frailty.
2. Enable staff to understand frailty as an end-of-life state, albeit with an unpredictable prognosis.
3. Enable patients and families to have realistic expectations and to be able to express wishes and preferences about future care.
4. Create a culture where staff feel confident about discussing advance care planning with patients and families.

We called the project "Courageous, Compassionate, Confident, Conversations", or the "The 4Cs Project". The project was owned and driven by the team supported by the Point of Care Foundation's Patient and Family Centred Care Programme.^{2,3} In its publication, the Lucian Leape Institute discussed the importance of finding joy and meaning in

work.⁴ “Joy in Work”⁴ had become an important part of our cultural ethos. Our matron put a lot of thought and energy into developing a multidisciplinary leadership team. We used different processes to get to know one another's psychological profiles. We spoke about “Work Family” and as we came to understand one another better we began to work better as a leadership team. When attending meetings in other hospitals that didn't use our approach, we realised how special what we were creating was. This awareness also gave us a confidence to begin to think about and articulate the kind of culture we wanted at Worcester City In Patient Unit. We aimed to help staff find meaning and joy in their work; we recognised that if staff felt happy at work, our patients and their families would be able to feel that.

We were keen to use that ethos in “The 4Cs Project”, to make it one that staff would really enjoy being part of, and could feel proud of. We had witnessed the benefits of celebrating things as we supported the team through a big change process; eg, the effect of taking a moment to celebrate when a nurse's daughter got married; wearing red and having little pink cupcakes at the MDT meeting on Valentine's Day, etc. We noticed how it lifted people and brought the team together, and as time progressed we witnessed our “team spirit” and resilience increasing. We suspended a fishing net from the ceiling of our training room to collect people's thoughts and ideas. We painted two walls of our Training Room with blackboard paint and began to draw the story of our project. We had a project launch with cake and invited *all* staff, the deputy director of nursing, the chaplain, and some guests from the Palliative Care Team and Worcester University.

At the outset, we sent questionnaires to staff. We embedded advance care planning as part of the MDT meetings. We held six training sessions: two on frailty, two on communication, and two on end-of-life care. These sessions were interactive and provided time and space for people to openly discuss more deeply and to share experiences and concerns. We hosted some social events for staff to talk about death and dying—some staff movie nights with popcorn and film discussion afterwards. We collected some of the staff's written personal stories, giving people a chance to share the deeper experiences that in many instances have fuelled their passion for wanting to be part of this creative work and to get these important conversations with patients and families right. We filmed some staff talking about how they felt about having these conversations and why they wanted to be part of the project.

We also changed the language we use from Discharge Planning to Future Planning. We audited how many patients had “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPRs) when they arrived at our community hospital setting compared to when they left us. The DNACPR was used as a proxy measure for advance care planning discussions.

LESSONS LEARNED

In this project, we created a “space” in which staff could become confident in having courageous, compassionate, confident conversations around death and dying. The safety and generosity of that “space” was critical. The experiences and conversations that took place along the way were as important as the data collected and the statistics produced. The qualitative data was as important as the quantitative.

We have created a culture of shared responsibility whether one is a doctor, a healthcare assistant, a nurse, or a therapist for bringing the good communication and advance care planning associated with palliative care to the people in our non-specialist community hospital who are living with frailty. Staff have overcome their initial concerns and lack of confidence; they now feel more able and willing to initiate conversations with patients and families about advance care planning and to seek out other staff if they need assistance to initiate or continue this conversation. The personal staff stories that have been shared have been precious and moving, and have allowed staff working alongside one another to reveal their individual humanity more deeply. The sharing and collaboration have strengthened the team and created a greater sense of community. It is our experience and belief that ultimately the care we give to patients and families is

deepened by the team having been able to share their own humanity in this way.

Listening skills and facilitating conversations have been an important part of the project. This project has given the leadership team more confidence to articulate the value of conversations with staff, patients, and families. It has also showcased the ability of staff to collaborate creatively. Capturing stories on film helped validate the power of storytelling and has been a particular joy. The stories and the films have also given us an excellent teaching kit to return to and reuse.

The spirit and feel of this project, coupled with the participants' deeper knowing of one another, created a space that continues to have an impact every day. Specifically, team members can have quality conversations with patients, their families, and each with other. In addition, the understanding and sensitivity that emerges from those conversations ultimately affects how patients and families experience being cared for by the team at Worcester City In Patient Unit. The project has also helped to create a culture where staff are beginning to engage differently with one another. An example of this new engagement is the opening up in group supervisions and 1:1s. It has also enhanced staff's ability to be present with patients and families more courageously and deeply around death, dying and frailty. Our project has helped "humanise healthcare" and has very much become a part of our "Joy in Work".

DESIGN INSIGHT

As a junior doctor, end-of-life care discussions are frequent conversations that require continual practice. Initially, open dialogue with the patient and family regarding end-of-life wishes is difficult. With minimal experience and perceived pressure to appear well informed can make this conversation stagnant and often awkward.

On arrival to hospital, numerous patients have not discussed their goals for end-of-life care. This conversation is often occurs under time constraints, limiting the patient's time, and likely ability, to ponder and digest further with family and friends. The 4Cs Project of initiating improvements in courage, compassion, confidence, and communication may enlighten the experience of people from all healthcare backgrounds to improve this important discussion.

Frailty, I would agree, is underestimated in its impact on the patient's outcome. It is essential for all health professionals to identify patient limitations and collaborate to determine if patient progress is as previously predicted. This should trigger early end-of-life care discussions and advance care planning, ensuring they take place prior to the moment the answer is urgently required.

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VIDEO RESOURCE

[Courageous, compassionate, confident, conversations](#): a video about The 4Cs Project.

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PEER REVIEW

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CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

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ETHICS COMMITTEE APPROVAL

None