The Conversation Project

CHAT Bundle

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Consider

Consider whether the patient has an uncertain prognosis or is nearing end of life?

Consider:

- Rockwood Clinical Frailty Scale
- SPICT - Supportive and Palliative Care Indicator Tool
- The 'Surprise Question'
- The patient's narrative
- Information from the family/carer
- Discuss at white board / MDT meetings
- Add Conversation Project magnet to the white board to flag Advance Care Planning conversations required / happening

Have

Have conversations with the patient & their family / carer to support Advance Care Planning:

- Think about the environment and your compassionate approach
- Check their understanding
- Ask whether the patient has an existing ReSPECT form
- Acknowledge uncertainty of recovery and the future
- Have honest conversations and explore 'what matters to you?'
- Listen compassionately to their concerns, wishes & preferences
- Discuss recommendations for future anticipatory care and treatment - ReSPECT
- Offer 'Planning ahead' leaflet

Advise

Advise the MDT following Advance Care Planning conversations:

- Share information on what matters to the patient, their wishes and preferences
- Complete a ReSPECT form
- Include information from Advance Care Planning discussions in the plan of care
- Document Advance Care Planning and ReSPECT conversations in the MDT record - Millennium Conversation Project Advance Care Plan template
- Discuss at MDT / White Board meetings

For information on the Conversation Project:

- For information go to the intranet and click 'P' for Palliative or 'E' for End of Life Care
- Contact the Palliative Care Team on ext 5567

Transfer

Transfer information to support continuity of care:

- Offer 'Planning Ahead' and/or 'My Wishes' leaflet to the patient and family
- Review or complete ReSPECT for discharge
- Inform the patient and family / carer that ReSPECT is the patient's property and should accompany them on any transfer of care
- Complete Millennium Conversation Project Advance Care Plan template and select to populate DEPART discharge summary to share Advance Care Plan discussions and recommendations
- Communicate with GP, DN or care home on transfer of care

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