Background and Introduction
The NMUH Specialist Palliative Care Team (SPCT) were finding that patients discharged from Critical Care with a treatment escalation plan ‘Not for readmission to ITU/HDU’ were experiencing high levels of suffering on the wards for several days prior to SPCT review. They were also dying within the same hospital admission and not reaching their preferred place of care. The team proposed the idea of having all patients from this group referred at point of CRC discharge which would give these patients faster access to expert symptom control, advanced care planning and transfers to preferred place of care.

Method
A baseline audit conducted on all patients discharged from CRC from 1/1/18–30/11/18 revealed that only 14% of patients with a TEP form ‘Not for admission to ITU/HDU’ were referred to SPCT at point of CRC discharge. Over 7 months several interventions were implemented through monthly PDSA cycles to improve the referral rate. This included emails sent to CRC staff, palliative care teaching at the CRC educational sessions and training of the critical care outreach team in making SPCT referrals.

Results
Overall there was an improvement of referral rate of this group of patients to SPCT from 14% to 70% during the 7 months where the interventions took place. Moreover, the increasing collaboration between the two teams through this QIP culminated in the introduction of a palliative care representative at the weekly CRC MDT meeting.

Conclusions
While an overall improvement in referral rate to SPCT was established it remains to be seen whether patient outcomes have improved due to this change. Thus a case note review will be conducted to assess this. Rotation of juniors in CRC means that the educational interventions need to be recycled biannually to keep up referral rate.

Background
It is becoming increasingly accepted that discussion and documentation of patient wishes and clinical decisions regarding treatment escalation planning are an essential part of patient care. Following the Tracey judgement, it became a legal requirement, rather than a recommendation, for doctors to involve patients and their families in DNAR decisions. A previous audit in the neurosurgical department found a high prevalence of patients at risk of deterioration with little evidence of attempt to discuss or document treatment escalation decisions (TEDs).

Aims
- To improve the documentation of TEDs in the neurosurgical department
- To improve confidence and communication about TEDs within the multi-disciplinary team

Methods
We conducted surveys of the multi-disciplinary team within the neurosurgical department to gain a better understanding of their opinions about the current discussion and documentation of TEDs in the department. These contained a mixture of rating scales and free text answers. Following this we engaged senior staff in plans to improve this by introducing these discussions to governance meetings and educated all members of the ward using e-learning and tea-trolley teaching.

Results
Amongst 18 healthcare professionals, 12 felt patients did not have clear TEDs. Ten felt discussions were not appropriately timed. Response themes included feeling unsupported, poor timing of conversations and low quality documentation. Following this a consensus decision from the consultant body mandated documentation of TEDs in patients presenting with chronic subdural haematomas. We have worked closely with the national ResPECT programme and established the neurosurgical ward as a lead for the introduction of the new form.

Conclusion
The neurosurgery department is now at the forefront of the move to improving discussions and documentation about patient wishes in the Trust. Additionally, we have opened the conversation within the multi-disciplinary team and provided training and education about the importance of TEDs.