A MORTALITY REVIEW OF CARE HOME RESIDENTS ADMITTED TO ACUTE HOSPITALS

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10.1136/spcare-2020-PCC.92

Background We are aware that the number of care home residents dying in hospital in our local area is higher than average. We conducted a mortality review focusing on this population to identify areas for improvement. Particular attention was paid to understanding the number of hospital admissions in last 90 days of life, impact of advance care planning (ACP) and barriers to achieving preferred place of death (PPD).

Methods A retrospective review of care home residents who died in hospital over a 3-month period starting on 13.09.18 was undertaken. These patients were known to the hospital palliative care team. Data was collected from the palliative care referral list, electronic patient records and further discussion in MDT.

Results 34 care home residents were admitted and died in hospital. A larger proportion of patients (56%) were admitted from residential homes compared to nursing homes (38%). The vast majority of these patients had a non-cancer diagnosis (91%). 59% patients had previous emergency admissions in the last 90 days of life and were discharged. 34% of these were discharged from A&E.

Despite 41% of patients having a DNACPR in place prior to admission, only 29% had EPaCCs record created, and only 15% of patients had a clear PPD documented. Multiple barriers to achieving PPD were highlighted. Results suggested that the most significant were that care homes were unable to meet patients’ needs (36%), rapid deterioration during admission (35%) and missed opportunities for ACP (21%). 32% of these patients changed PPD to hospital, as they were happy with care received.

Conclusions Lack of ACP and communication has been associated with care received. These patients changed PPD to hospital, as they were happy with care received. Despite 41% of patients having a DNACPR in place prior to admission, only 29% had EPaCCs record created, and only 15% of patients had a clear PPD documented. Multiple barriers to achieving PPD were highlighted. Results suggested that the most significant were that care homes were unable to meet patients’ needs (36%), rapid deterioration during admission (35%) and missed opportunities for ACP (21%). 32% of these patients changed PPD to hospital, as they were happy with care received.

ADVANCE CARE PLANNING IN HOSPITAL FAST TRACK DISCHARGE PATIENTS: A QUALITY IMPROVEMENT PROJECT

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10.1136/spcare-2020-PCC.94

Introduction There is national focus on earlier identification of patients in their last year of life and allowing them to express their preferences through the process of Advance Care Planning (ACP). Despite training on prognostic models, many clinicians find it difficult to identify which patients are suitable for ACP discussions. Expedited hospital discharges utilising NHS Continuing Care Fast Tracking potentially provide an opportunity to undertake and record ACP, as these patients are anticipated to be approaching the end of life. The aim of this project was to increase the number of ACP discussions in Fast Track discharge patients.

Method This project took place using a Plan, Do, Study, Act approach in three-month iterative cycles. Fast track discharge patients were identified from databases held by the palliative care and discharge teams. The electronic hospital records of patients identified from both databases were reviewed retrospectively to determine if there was any evidence of ACP. The Co-ordinate My Care (CMC) database was accessed to see if the patient had a CMC record.

Results Overall, the results showed an overall increase in ACP/CMC from 40% at baseline to 53% at 3 months, 98% at six months, 98% at nine months and 100% at 12 months. This improvement was due to:

- Education and training to junior doctors on ACP/CMC
- Revision of the hospital’s ACP proforma to improve quality of information shared
- Simplification of the ACP/CMC process within the hospital resulting in improved communication with external organisations
- Addition of a prompt regarding completion of ACP/CMC onto NHS Continuing Care Fast Track tool paperwork