A MORTALITY REVIEW OF CARE HOME RESIDENTS ADMITTED TO ACUTE HOSPITALS

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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 improved with a dedicated palliative care section on hospital discharge letters. Education tailored to acute areas of the trust (A&E and MAU) is being provided, and increased integrated working in these areas is being explored.

CONTINUOUS SUBCUTANEOUS INFUSION PRESCRIBING PRACTICES IN END OF LIFE CARE: A MULTICENTRED RETROSPECTIVE REVIEW

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Background Continuous Subcutaneous Infusion (CSCI) prescription practice is an area of high clinical importance across all palliative care settings. Frequent evaluation of CSCI prescribing is essential to ensure appropriate and justified prescriptions are made.

Methods Across three palliative care settings, a hospice and two hospitals (A and B) within a trust, prescriptions of anticipatory (PRN) medications, opioids and continuous subcutaneous infusions (CSCI) of 60 patients who died in April 2019 were reviewed retrospectively.

Results In the hospice anticipatory CSCIs were prescribed for all patients expected to deteriorate with a range given

for each medication. This practice was not observed in the hospital setting where it is not recommended to prescribe anticipatory CSCIs. 70% of the hospice patients had a CSCI in use at the end of life compared to 25% of the hospital patients. All hospital CSCIs contained midazolam (vs 71% in the hospice), however the total number of patients receiving midazolam CSCI was higher in the hospice. The numbers of patients dying with a CSCI containing an anti-secretory agent was low in all settings (20% at hospice, 5% A, 10% B). No hospital patients were receiving anti-emetic medication CSCI compared to 57% of hospice patients. In the hospice, patients died with between 0–5 medications administered CSCI, compared to 0–3 in the hospital setting.

Conclusion There were variations in the prescription of CSCIs for patients dying in an acute hospital compared with a hospice. Not only will this likely reflect the varying complexity of patients within the different settings but also staff confidence and competence in recognising and managing symptoms of patients who are at the end of their lives. Patient comfort at the end of life was not evaluated in this audit, review of clinical notes would guide further work.

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

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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 55% 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

Conclusion Expedited hospital discharges utilising NHS Continuing Care Fast Tracking provide an opportunity to undertake and record ACP. Undertaking ACP discussions at this point in the patient's care appears to be acceptable to both patients and healthcare professionals.

75 SYMPTOM CONTROL MEDICATION FOR PATIENTS DYING IN CRITICAL CARE: SYSTEMATIC REVIEW OF THE LITERATURE AND CURRENT PRACTICE IN CHESHIRE AND MERSEYSIDE

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Background Symptom control at the end of life within Critical Care settings varies. Within the literature there is no consensus for titration of infusion rates, the use of PRN medications or subcutaneous infusions.

Methods A literature review was performed, the databases MedLINE, EMBASE and CINAHL searched using relevant terms and results independently reviewed. A case note review was undertaken via an electronic proforma sent to Acute and Specialist Trusts with Critical Care units in Cheshire and Merseyside.

Results 633 articles were identified from the literature search, 66 having full text review, 14 accepted. These highlighted a wide range of doses prescribed, including 0–217 mg/hr of Morphine being reported. 95 case notes reviewed. Mean age was 69, 60% were male. 63% had Specialist Palliative Care input and 80% remained in Critical Care until death. There were discussions relating to dying in 96% of cases, 80% had a documented assessment of symptoms at the time dying was recognised. There was a wide range of time from recognising dying to death, 5 minutes to 9 days. When dying was recognised, 52% of patients were receiving intravenous infusions for sedation, symptom control or inotropes. After dying was recognised, 64% received medications via continuous infusion, 30% intravenous, 28% subcutaneous, 6% both. 65% of patients had anticipatory medication prescribed which increased to 83% when SPCT were involved. The mean dose of Morphine administered when dying recognised was 4.5 mg/hour, vs 5.9 mg/hour at the time of death, for Midazolam 1.5 mg/hour vs 3 mg/hour.

Conclusions Within Critical Care we found a wide range in time from withdrawal of life sustaining interventions to death. Routes and doses changed over this period and patients were more likely to have PRN medications prescribed when SPCT were involved. Doses of medication given by intravenous infusion were lower than the average doses reported in the literature.

76 AN ANALYSIS OF THE QUALITY OF ADVANCED CARE PLAN AND DNACPR DOCUMENTATION FOLLOWING THE INTRODUCTION OF THE RESPECT PROCESS

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An Advanced Care Plan (ACP) allows discussion and documentation of patient preferences for future medical care, not only limited to resuscitation. Despite national guidance, communication remains poor and there is inconsistent documentation of ACP and DNACPR decisions, potentially resulting in inappropriate treatment and unnecessary hospital admissions. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a newly introduced emergency care plan which aims to help support discussions and record recommendations. We assessed the quality of ACP and DNACPR documentation at a UK District General Hospital before and after introducing ReSPECT.

Retrospective data was collected on all patients from elderly care wards (one male and one female) in March 2018 and March 2019 through case-note review following ReSPECT going live in October 2018. Section headings on the form were used as basis for collection. Data also included ACP/DNAR decision communication on discharge paperwork.

The March 2018 cohort included 87 patients (35 female and 52 male) with 113 patients (67 female and 46 male) in March 2019. In patients who had an ACP discussion, there was an increase from 68.2% to 100% of the specific nature around this documented, and it was communicated better in discharge documentation (81.8% to 100%). Furthermore, in patients whom DNACPR was agreed, there were improved levels of recorded documentation from 79.4% to 87.1%.

ACP and DNACPR decisions are individual to each patient and pre-ReSPECT form data shows documentation was poor. However, following introduction of the ReSPECT form there were significant improvements noted in two key areas - in clinical notes for DNACPR decisions and subsequent discharge paperwork, and following ACP discussions there was an improved level of documentation regarding the specific nature of the ACP. We have demonstrated that the ReSPECT form can empower clinicians to ensure patients have an appropriate care plan documented to guide future care.

77 IMPROVING END OF LIFE CARE IN AN ACUTE SURGICAL UNIT AND TRAUMA TEAM – A QUALITY IMPROVEMENT PROJECT

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Objectives To audit end of life care (EOLC) delivered by the Acute Surgical Unit (ASU) and Trauma team at Kings College Hospital against local guidelines, and to identify methods to improve quality of care.

Methods Retrospective analysis of electronic notes of all patients who died under the care of ASU/Trauma between August and November 2018. Patients who had isolated neuro-surgical injuries, were transferred to another team more than 24 hours before death, or who died unexpectedly were excluded. Data concerning the five priorities of care for the dying person were extracted using a standardised tool. Interventions carried out after cycle one included junior doctor refreshers, EOLC lanyard prompts and posters in the doctors' office, with repeat data sampling from April to July 2019 inclusive.