Improving use of co-ordinate my care

Christopher Doyle, Joy Ross. St Christopher’s Hospice

Introduction Co-ordinate my care (CMC) is the pan-london electronic patient record system for palliative care patients. It facilitates sharing urgent care records across settings, linking services which patients may access (GP, ambulance, district nurses, palliative care). By creating records and working with local services to update records, we aim to improve 'joined up working' for our patients.

Aims/objectives To audit use of CMC for patients under the hospice including numbers of patient consented/records created, congruence of information recorded with hospice electronic records and access of records by emergency services.

Methods We conducted snapshot audits of records in December 2018, subsequent QI initiatives including staff training and integration of CMC reviews into MDM meetings, with re-audit December 2019. Each audit examined 200 patient records, 100 indicated as 'CMC record created' on our hospice system and 100 indicated to have no record. Patients were randomly selected; 40 from each service: Bromley community, Bromley care co-ordination, croydon community, Lambeth/Southwark/Jewish community and sydenham outpatients. Information was cross-checked against the live CMC record. Standards included: 90% of patients should have a CMC record, 95% should have documentation of consideration of CMC, 95% of CMC records should have resuscitation and ceilings of care decisions recorded with congruence between systems. We also recorded whether CMC records were accessed by OOH services.

Results Comparing data from our initial audit to the re-audit; 61% vs 73% of patients under our care were consented to have records created. Of these >95% had a live CMC record. For those not consented by us 220-40% had a live record across each of the 5 services. Between audits, numbers of patients with CMC records increased from 48-60% to 58-68%. Discussion of CMC with patients increased from 48-53% to 70-93%. Recording of DNAR status averaged >95%. Congruence of DNAR decisions was 82% with ceilings of care 61% congruent. Inclusion of hospice contact details varied across teams (30 to 74%). Records were accessed by out of hours services for 13 of these patients.

Conclusion Use of CMC is increasing with access to records by OOH services. Further QI initiatives to drive numbers and quality of records will be discussed with impact of OOH records accessed on patient outcome.

98 Improving use of co-ordinate my care electronic patient record at St Christopher’s Hospice – completing the audit cycle

Christopher Doyle, Joy Ross. St Christopher’s Hospice

Abstracts

Improving Use of Co-Ordinate My Care Electronic Patient Record at St Christopher’s Hospice – Completing the Audit Cycle

Christopher Doyle, Joy Ross. St Christopher’s Hospice

Introduction Co-ordinate my care (CMC) is the pan-london electronic patient record system for palliative care patients. It facilitates sharing urgent care records across settings, linking services which patients may access (GP, ambulance, district nurses, palliative care). By creating records and working with local services to update records, we aim to improve ‘joined up working’ for our patients.

Aims/Objectives To audit use of CMC for patients under the hospice including numbers of patient consented/records created, congruence of information recorded with hospice electronic records and access of records by emergency services.

Methods We conducted snapshot audits of records in December 2018, subsequent QI initiatives including staff training and integration of CMC reviews into MDM meetings, with re-audit December 2019. Each audit examined 200 patient records, 100 indicated as ‘CMC record created’ on our hospice system and 100 indicated to have no record. Patients were randomly selected; 40 from each service: Bromley community, Bromley care co-ordination, Croydon community, Lambeth/Southwark/Jewish community and Sydenham outpatients. Information was cross-checked against the live CMC record. Standards included: 90% of patients should have a CMC record, 95% should have documentation of consideration of CMC, 95% of CMC records should have resuscitation and ceilings of care decisions recorded with congruence between systems. We also recorded whether CMC records were accessed by OOH services.

Results Comparing data from our initial audit to the re-audit; 61% vs 73% of patients under our care were consented to have records created. Of these >95% had a live CMC record. For those not consented by us 220-40% had a live record across each of the 5 services. Between audits, numbers of patients with CMC records increased from 48-60% to 58-68%. Discussion of CMC with patients increased from 48-53% to 70-93%. Recording of DNAR status averaged >95%. Congruence of DNAR decisions was 82% with ceilings of care 61% congruent. Inclusion of hospice contact details varied across teams (30 to 74%). Records were accessed by out of hours services for 13 of these patients.

Conclusion Use of CMC is increasing with access to records by OOH services. Further QI initiatives to drive numbers and quality of records will be discussed with impact of OOH records accessed on patient outcome.

99 To Feed or Not to Feed? Review of Practice in an acute hospital trust around initiation and withdrawal of parenteral nutrition (PN) in palliative patients

David J Matthews, Farida Malik. East Sussex Healthcare NHS Trust

Background/Introduction National and European guidance around use of PN in palliative patients emphasises the need to consider risks, benefits, and impact on QOL with it unlikely to be appropriate in the last weeks of life. Starting PN can delay discharge from hospital to other settings and affect PPC/PPD.

Aims/Objectives To assess whether local processes around initiating and withdrawing PN for hospital inpatients with palliative care needs are in line with current guidance.

Methods Retrospective case review: All Patients prescribed PN feed over a 6-month period identified by pharmacy and known to the hospital supportive and palliative care team (SPCT) were recruited and their notes reviewed regarding indication for PN, evidence of discussions around initiation and withdrawal, date PN started and stopped, interventions planned/ performed, details of SPCT involvement, and patient outcomes. Data analysed using descriptive statistics.

Results 183 patients received PN over 6-month period. 33 were known to SPCT. SPCT involvement began after PN initiation for 77% of patients. Wide range of indications for initiation, most common being oesophageal obstruction (16%). Most commonly withdrawn because patient approaching terminal phase (52%). Relevant documented discussions with patients/families recorded in 29% prior to initiating PN (none involved SPCT) and 26% prior to withdrawing PN (half involving SPCT). Nearly half (48%) of patients died within 2 weeks of starting PN (65% within 4 weeks). Importantly 26% died within 24 hrs of stopping PN. Over 2/3 died in hospital. 65% had no intervention planned to stop the need for ongoing PN at the time of initiation. Findings showed results were not in line with current national guidance.

Conclusion/Discussion Decision for SPCT to be involved in all MDT discussions prior to PN initiation in palliative patients

A44 SPCARE 2021;11(Suppl 1):A1–A63

BMJ Support Palliative Care: first published as 10.1136/spcare-2021-PCC.116 on 16 March 2021. Downloaded from http://spcare.bmj.com/ on May 21, 2021 by guest. Protected by copyright.