Improving use of Co-Ordinate My Care: electronic patient record at St Christopher’s Hospice – Completing the Audit Cycle

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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/lewisham 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.
incorporated into new hospital guidelines. Introduction of pro-forma planned to record initiation discussions in medical notes. Outcomes following changes will be reaudited.

100 OUTCOMES FOR INPATIENTS WITH CHRONIC LIVER DISEASE, IS THERE A NEED FOR BETTER PALLIATIVE CARE PROVISION?

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10.1136/spcare-2021-PCC.118

Background Liver disease is the third largest cause of UK death in working age people and is prevalent locally. Early access to palliative care is associated with better quality of life and fewer hospital admissions. This study explores prognosis of inpatients with chronic liver disease (CLD) and their interaction with palliative care.

Methods New Cross Hospital inpatients with CLD, without malignancy, were discussed at the weekly liver Multidisciplinary Team (MDT) meeting (2014 to 2016) and followed up until 2020. Data were retrospectively collected using written and electronic records to determine baseline factors, liver disease severity, follow up and intervention, and analysed for timepoint analyses of death.

Results 112 patients data were analysed. The mean age was 55. 86% (96) had alcohol related liver disease. Other primary aetiologies included non-alcoholic fatty liver disease, cholestatic liver disease and drug-induced liver disease. 51% (57) died within a year of MDT, at least a further 21% (23) died during follow up. 58% (42) with Child-Pugh C grading died within a year of MDT, a further 18% (13) died during follow up. 3 patients went on to liver transplantation. Child-Pugh C grading was 74% sensitive for identifying those who will die within 1 year, but only 42% specific. Child-Pugh B or C was 100% sensitive for death within 1 year, but only 9% specific. 47% with Child-Pugh C, 37% of Child-Pugh B and 20% of Child-Pugh A were known to specialist palliative care team (SPCT). 56% of deceased patients were known to SPCT.

Conclusions This data confirms the poor prognosis of inpatients with CLD and demonstrates a need for greater integration of advance care planning principles and palliative care support. Further research is needed to assess which interventions would be beneficial and acceptable to these patients, or how we identify those who would most benefit.

101 A KETAMINE PATHWAY: RESPONDING TO A NEED FOR QUALITY IMPROVEMENT IN KETAMINE BURST THERAPY

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10.1136/spcare-2021-PCC.119

Background Ketamine is an anaesthetic agent which can be used to treat pain that is unresponsive to standard treatments. The Ketamine Pathway outlines recommended practice for the use of ketamine burst therapy over the prior three years. The electronic case notes were subsequently analysed.

Results Of the 20 patients who received ketamine, 17 (85%) completed the five-day regimen. Prior to commencing treatment, all patients had a clearly documented rationale and indication. During treatment, 13 patients (65%) received ketamine burst therapy. Monitoring of respiratory rate and conscious level at baseline and during treatment was significantly below standard. Only a small proportion of patients (10%) had adequate monitoring of blood pressure and heart rate during treatment; with 4 patients (20%) having documented evidence of a significant rise in either heart rate or blood pressure. Of these, 3 received a ketamine dose alteration.

Conclusion The audit findings strongly suggested that monitoring during ketamine burst therapy was suboptimal and fell below regional standards. As this posed a potential patient safety issue, the findings were presented at a local audit meeting. In response, a Ketamine Pathway was developed to enhance and standardise patient care for those receiving ketamine burst therapy. The Ketamine Pathway outlines recommendations for counselling, opioid dose reduction prior to treatment and twice daily monitoring of vital signs during treatment. It includes a pre-populated prescription and vital sign monitoring chart. Early evaluation of the use of the Ketamine Pathway in clinical practice is encouraging and re-audit is planned for 2021.