Introduction NICE guidance recommends that doctors need to identify patients who are approaching their final year of life, through the utilisation of tools such as the Clinical Frailty Score (CFS). The ‘Getting it right first time’ (GIRFT) document recommended that all local health systems identify older people in the last phase of life and offer them Advanced Care Planning (ACP). Wigan has a large population of frail patients who would benefit from ACP discussions.

Aim Initiate a strategy for identifying patients with severe frailty and establish a process for implementing ACP.

Method Retrospective discharge data was used to identify patients aged >65 years, with a CFS of >7, over an 12-month period. The cohort was examined to see if they had been recognised as a patient who would benefit from ACP, or if an aspect of ACP had been completed during their admission. In total, 50 patients were selected.

Results Initial data showed that we were poor at identifying and completing ACPs for patients with severe frailty. No advanced care planning decisions (0%) were taken during this period. Education (PDSA cycle 1) on ACPs for the ward doctors led to an improvement regarding ACP discussions. However, we were still poor at identifying severe frailty. Education (PSDA cycle 2) for nursing staff was undertaken, which highlighted inaccuracies with calculating CFS. Further PDSA cycles included a geriatric frailty score assessment, introduction of Electronic Palliative Care Coordination Systems (EPACCS) and frailty posters and cards.

Conclusion Severe frailty is an end-of-life state and should trigger a healthcare professional to identify and sensitively discuss end of life needs and preferences. Despite the best intentions of the medical team, implementing a sustained and successful approach to ACP remains challenging within an inpatient setting.

END OF LIFE CARE ON ICU
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Background End of life care (EOLC) on intensive care units (ICU) comes with a number of challenges. This includes rapidly deteriorating patients, complex decisions regarding the withdrawal/cessation of medical interventions, specific care needs for sedated patients, and psychological considerations for grieving family and friends.

Methods A multiple cycle QIP was carried out at Newham University Hospital. EOLC in ‘expected deaths’ was audited against local guidance. This is summarised in the Barts Health individualised care plan for the dying patient; Compassionate Care Plan (CCP). Data was collected through review of mortality lists and electronic patient records. Further cycles were completed following interventions; firstly, EOLC trolleys with information for staff, patients and families, alongside creating a designated EOLC champion nursing role. Secondly teaching sessions on EOLC.

Results Initial data was taken from the two month period May-June 21. There were 14 expected deaths: 4 patients were referred to palliative care (29%); 2 patients were supported with the CCP; 2 patients had documentation into consideration of spiritual support. For patients not sedated, medications for symptom control were not always prescribed.

Following the first interventions, Jan-Mar 2022 was analysed. There were 23 expected deaths: 8 (35%) were referred to palliative care; 6 patients (26%) were supported with the CCP; 12 patients had documentation pertaining to symptom control; 9 (39%) patients had documentation of their spiritual needs, with chaplain visits.

Following the second intervention, a further two-month period was assessed. There were 14 expected deaths: 50% were referred to palliative care; 6 patients had documented considerations into spiritual care; unsedated patients had their symptoms assessed through documented discussion with them.

Conclusion This QIP demonstrated interventions such as education, a designated EOLC champion and easily accessible resources increased spiritual care considerations, improved management of patient’s symptom control needs and increased referrals to the palliative care team.