Background

The End-of-Life Care (EoLC) Strategy 2008 highlighted the importance of early identification of potential for dying and Advanced Care Planning (ACP). Early awareness of poor prognosis helps patients and their relatives to understand their illness and make informed choices about their care; for instance whether to decline aggressive intervention and hospitalisation if it is unlikely to improve their quality of life.

Aims and Objectives

To prompt early communication within the MDT and with patients and their relatives about ACP for those deemed to be in their last year of life.

Method

Data from 40 discharged patients, who had been identified as likely being in their last year of life, was collected in each audit cycle.

Cycle 1 was a retrospective case notes analysis from one Care-of-the-Eldery (CoE) ward. Five key areas of ACP were reviewed: resuscitation status, prognosis, ceiling of care, readmission plans, patient/family awareness of condition and prognosis.

Prior to cycle 2, an ACP Summary proforma was implemented where discussions around the five key areas could be summarised. It was introduced at a CoE department meeting and teaching sessions were held for junior doctors.

Results

Tables 1 and 2 illustrate our findings.

Table 1 Documentation in Medical Notes

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Cycle 1</th>
<th>Cycle 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation Status</td>
<td>100%</td>
<td>82%</td>
<td>97%</td>
</tr>
<tr>
<td>Prognosis</td>
<td>95%</td>
<td>55%</td>
<td>95%</td>
</tr>
<tr>
<td>Ceiling of Care</td>
<td>95%</td>
<td>41%</td>
<td>100%</td>
</tr>
<tr>
<td>Readmission Plans</td>
<td>95%</td>
<td>14%</td>
<td>100%</td>
</tr>
<tr>
<td>Patient/family awareness</td>
<td>95%</td>
<td>77%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2 Discharge Documentation

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Cycle 1</th>
<th>Cycle 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation Status</td>
<td>100%</td>
<td>6%</td>
<td>89%</td>
</tr>
<tr>
<td>Ceiling of Care</td>
<td>100%</td>
<td>56%</td>
<td>100%</td>
</tr>
<tr>
<td>Readmission Plans</td>
<td>100%</td>
<td>33%</td>
<td>100%</td>
</tr>
<tr>
<td>Patient/family awareness</td>
<td>100%</td>
<td>59%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Cycle 1 Documentation regarding prognosis and ceiling of care (escalation plans) was poor; often it was very difficult to find in the medical notes. On call teams had to make escalation plans for 4 patients. Patients and relatives were not always informed in a timely fashion leading to 3 complaints.

Cycle 2

Re-audit results following the implementation of the ACP Summary showed an improvement in all 5 key areas.

Conclusion

The ACP Summary ensured easily accessible information and prompted early discussions with patients, relatives and within the MDT. It improved communication with GPs on discharge.