Comparing the Assessment of End of Life Care in the Structured Judgement Review with an End of Life Audit

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Background The Structured Judgement Review (SJR) is a validated and standardised method for reviewing case notes of patients who died in hospital. One section assesses end of life care (EOLC); this can be rated from very poor to excellent. This audit aims to evaluate whether the SJR is providing us with an accurate assessment of the quality of EOLC in an Oncology inpatient department.

Methods This is a retrospective audit of adult patients that died on Oncology wards in 2017 and had an SJR completed. The end of life audit assessed whether the Hospital Trust’s Key Performance Indicators (KPIs) were achieved. National standards were used to audit specific aspects of the individualised care plan. The care ratings and comments from each SJR were then compared with the end of life audit.

Results The notes of six patients were reviewed. The SJR ratings for EOLC were ‘very good’ in five cases and ‘excellent’ in one. However, the EOLC audit using Trust KPI’s showed more variation in the quality of care. In three cases where the SJR rated ‘very good’ or ‘excellent’, this compared well with the EOLC audit where they achieved 80%–90% of Trust KPI’s. In two cases where the SJR rated ‘very good’, they only achieved 30% of Trust KPI’s. The final case was again rated ‘very good’, but only achieved 50% of Trust KPI’s. The comments in the SJR did not discuss the same issues that the EOL audit raised. For example, some focused on treatment escalation plans being completed rather than the quality of care.

Conclusion The recorded quality of EOLC according to SJR’s did not consistently reflect the quality of care being given. In order to improve the accuracy of the SJR, we attached key KPI’s on EOLC to the SJR form as a prompt for reviewers.

Archeological Dig: A Historical Review of Local Evidence, Guidelines and Clinical Practice in Response to the Gosport Enquiry

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Background The Gosport Report suggests over 450 patients died due to ‘dangerous doses’ of medication combinations without clinical indication. A cross-boundary integrated specialist palliative care service reviewed factors influencing prescribing culture for patients approaching end-of-life.

Methods A historical review of pain management and syringe driver use was considered alongside locality guidelines. Training programmes were reviewed and meetings held with stakeholders. Audits were undertaken to seek assurance of safe local prescribing practices.

Results

- During the Gosport period, there was clear guidance available for safe opioid starting doses, dose equivalences & syringe driver use.
- Medical Devices Alerts regarding the risks of multiple syringe driver devices in use, led to use of a single device across locality. Local guidelines have always stated no indication for ‘anticipatory prescribing for medication via a syringe driver’.
IMPROVING THE PRESCRIPTION OF ANTICIPATORY MEDICATIONS FOR ADULTS RECOGNISED AS DYING IN A DISTRICT GENERAL HOSPITAL

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Introduction The NICE quality standards for care of adults in the last hours/days of life state that all patients should have appropriate as required medication (PRN) prescribed for the symptoms (pain/breathlessness, agitation, nausea/vomiting and respiratory secretions) that can occur at the end of life (EoL). This quality improvement project tested the adherence to this in one UK district general hospital.

Aims To investigate whether PRN anticipatory medications were prescribed in accordance to trust guidelines to inform future quality improvement work.

Method This was a prospective audit of 20 consecutive patients across adult wards in June 2018. Drug charts were audited using a tool based on the trust guideline, and the auditor met with junior doctors to discuss concerns around prescribing.

Results 25% (n=5) of prescriptions were accurately compliant with guidelines. In medications for pain relief and agitation drug dose was correct in 75% (14) and 60% (12) respectively, however dose frequency was incorrect in 45% (9) and 70% (14), with too long a dose interval in 40% (8) and 50% (10) respectively. The PRN medication with the most errors were medication for nausea/vomiting and respiratory secretions with the dose missing or incorrect (no maximum 24 hour dose recommendation) in 95% (19) and 80% (16) respectively. Discussion with junior doctors highlighted a lack of awareness of the guidelines.

Conclusions Despite the existence of trust guidelines prescription errors for anticipatory medication at EoL were common. The main concern being patients may have symptoms under treated due missing drugs or too long dose frequency. In collaboration with the specialist palliative care team, pharmacy and junior doctors a poster was created and displayed across all wards. This was supported by teaching sessions delivered by a junior doctor to junior doctors to promote the content of the poster. The adherence to guidelines will be re-audited in 2019 and included in the presentation.