

107

RESULTS THROUGH RELATIONSHIPS: DEVELOPING CORE CAPABILITIES IN END OF LIFE CARE

Saskie Dorman, Adrienne Rogers, Fiona Macdonald, Sarah Howard, Andy Brogan. *Dorset End of Life Care Partnership, Dorset Clinical Commissioning Group, Easier, Inc*

10.1136/bmjspcare-2019-ASP.130

Background There are numerous performance indicators in end of life care, including those used by health and social care regulators. This can make it hard to focus on what really matters. As part of our system-wide work to improve personalised care and support towards the end of life, we focused on core capabilities. What do we need to be really good at, consistently, to make sure that everyone has as good an experience as possible in their last year of life?

Methods We used the clean framework – ‘clean in, clean through, clean out’ – establishing sound beginnings, middle and endings – to create a list of capabilities. We refined these iteratively, focusing on elements which are necessary and sufficient. The core capabilities were validated with stakeholders including people and their families, health and social care clinical and managerial staff.

Results Our core capabilities are:

- We recognise when you may be in the last months of your life.
- We all understand what really matters to you and your family, and focus on this together.
- You are supported to live well in your own way, as part of your community, finding moments of joy where possible.
- You are supported to anticipate what may happen towards the end of your life. Your wishes are shared as appropriate (with your consent) so that you are supported through times of illness in a way which feels right to you.
- You are as comfortable as you want to be, including in the last days of your life.
- Those close to you feel supported, including after your death.

Conclusion The clean framework offers a useful way to structure core capabilities, which can be used to focus on what really matters both in everyday practice and in organisational review of end of life care.

108

IMPROVING DISCHARGE DECISIONS AND THEIR DOCUMENTATION AT ST LUKE'S HOSPICE INPATIENT CENTRE

Kate Atkinson, Rachel Parry, Samuel Fingas. *St Luke's Hospice, Sheffield*

10.1136/bmjspcare-2019-ASP.131

Background In keeping with the ‘Care of dying adults in the last days of life’ NICE guidelines, inpatients are consistently prescribed anticipatory medications. However, decisions for inpatients discharged home were unclear. Evaluating clinical practice focusing on anticipatory prescribing, subsequently including other discharge decisions, was done to support multiple implementations to improve care.

Methods A retrospective baseline service evaluation of 16 patients discharged from the Inpatient Centre was performed. A new Standard Operating Procedure (SOP) was designed, liaising with the multidisciplinary team. Patients’ Phase of Illness guided decisions regarding anticipatory medication and community prescription charts on discharge. Changes to

documentation were implemented, including medical discharge letters, Advance Care Planning documents and ward round decision aids. Links with GP out of hours (OOH) services were established. New standards were re-audited a year later, including 17 patients.

Results 44% vs 41% patients were discharged with anticipatory medication. However, it was unclear for the remaining 56% in the first cycle if anticipatory medication had been considered as there was no documentation. Following implementation, documentation in both the medical notes and medical discharge letters improved (44% and 71% vs 88% and 100% respectively). 83% vs 100% of those discharged with anticipatory medication received all four core medications. Community administration prescriptions increased from 14% to 100%. All patients’ medical discharge letters are now sent to GP OOH (previously 0%). The new electronic ACP proforma is being used as are Yorkshire Ambulance Service system alerts to help keep people at home.

Conclusions The SOP has been imbedded in clinical practice and provides much needed guidance for consistent decision-making regarding discharge, of which anticipatory medications is a component. Documentation has significantly improved, but the most significant change has been communication between specialist palliative care and primary care health providers including out of hours services to improve patient care.

109

RETROSPECTIVE CLINICAL CASE REVIEW OF HOSPICE IN-PATIENTS WHOSE LENGTH OF STAY EXCEEDED THIRTY DAYS

Hannah Zacharias. *St Gemma's Hospice*

10.1136/bmjspcare-2019-ASP.132

Background St Gemma’s Hospice mean length of stay (LOS) is fourteen days, with a range from one to 104 days in 2018. Discussions regarding possible discharge from the hospice are initiated with patients if appropriate. Understanding some of the reasons why some patients have a longer LOS may assist multi-disciplinary team (MDT) decision making with a patient and their family, and potentially facilitate re-direction of hospice resources.

Methods SystmOne database identified patients whose LOS exceeded 30 days, over a one year period. Consultant combined review of SystmOne and paper hospice notes was conducted to draw themes and collate available numerical data, such as modified Barthel score and Australia-modified Karnofsky Performance Scale (AKPS).

Results 33 patient notes were reviewed. Five patients LOS greater than 70 days, 15 patients 42–69 days and 13 patients 31–41 days. 20/33 (60%) patients died during their admission. Of these 20, 14 patients had discharge planning commenced and then later stopped. The patient lived alone, with a dependent or there was presence of significant carer strain in 24/33 cases (73%). 15 patients (45%) had a Barthel score of less than 20 and an AKPS of 40% or less. Complex symptoms or a variable clinical condition was felt to be contributory in only 4 cases. In 18/33 (55%), patient or family expressed a wish to remain in the hospice, rather than be discharged. Other factors included delays in funding or waiting for care packages or care home placements.