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

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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.

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

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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.

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

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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.

Conclusions There are several shared factors within the cohort of patients with a LOS greater than 30 days. Commencing discharge planning, is not always the patient's preferred choice, involves several MDT members and occurred in 82%; however only 39% patients were discharged. A subsequent prospective service evaluation will now aim to assess the impact of each of these factors.

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EVALUATION OF MULTI-PROFESSIONAL RESPONSES TO SPECIALIST PALLIATIVE CARE SERVICE PROVISION USING CLINICAL ALIGNMENT

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Background A change in practice within a hospital specialist palliative care team (SPCT) to allocate each specialist team member to an identified group of clinical areas. The aim being to improve effectiveness of the service with increased continuity of contact for patients, relatives and multi-professional staff. We describe this as clinical alignment.

Aims To evaluate the impact of introducing a change in SPCT service delivery by measuring multi-disciplinary responses about the effectiveness, accessibility and quality of SPCT provision. To also evaluate the impact of Clinical Alignment in supporting ward staff to meet their educational and development needs.

Methods A questionnaire was developed for multi-professional ward teams across adult care designed to elicit their experience of SPCT provision. A second questionnaire was designed for the SPCT. Questionnaires were given out 9 months after adopting clinical alignment and were anonymised with only the role of the respondent identifiable. 180 questionnaires were given to ward teams. Response rate was 70% (n=126). SPCT response rate was 100%.

Results Of multi-professional team responses 94% were somewhat satisfied or very satisfied with SPCT input. 79% responded that input was of high or very high quality, 82% that the SPCT was very or extremely responsive, 86% somewhat or very approachable and 90% somewhat accessible or very accessible. 53% Respondents felt supported in education and development. Incomplete questionnaires were returned, completed data from these was included. SPCT responses were generally positive, with agreement to continue to work with clinical alignment in service delivery.

Conclusions Multi-professional and SPCT responses were overwhelmingly positive. All SPCT responses indicated a contribution to the education and development of multi-professional colleagues that was endorsed by only a small majority of respondents. This variance will inform service development.

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OUT OF HOURS SUPPORT: A REVIEW OF THE 24 HOUR ADVICE LINE FOR SOUTH EAST WALES FROM MARIE CURIE HOSPICE CARDIFF AND THE VALE

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Introduction The Marie Curie Hospice, Cardiff and the Vale runs a twenty four hour specialist palliative care telephone advice service for patients, relatives and other health care

professionals. It supports a seven days a week clinical nurse specialist (CNS) palliative care service in all settings across South East Wales. Calls are handled by hospice in patient nurses. Calls from healthcare professionals are passed onto the appropriate specialist palliative care team which consists of a CNS team and on call specialty trainees or consultants in palliative medicine. Calls from patients and relatives are either dealt with by the inpatient nurses, passed onto the appropriate specialist palliative care team or GP out of hours.

Method A Retrospective review of advice calls received at the hospice between 1st April-20th September 2018.

Results There were 336 calls to the advice line in the 6 month period, a mean of 56 calls per month. Of these 34% were previously known to Marie Curie. 74% of the calls were from the patient's own home. The duration of advice calls to the inpatient nursing staff amounted 46.2 hours. 53% of the calls were over the weekend and 27% of calls were passed onto the oncall Doctor. 17% of the calls were passed onto the CNS. Of the callers to the advice line 36% were relatives and 21% were other doctors (GP or junior doctor) calling for advice. The majority of calls to the advice line were regarding symptom control, patient advice or medication queries.

Conclusion As demonstrated, the advice line is a successful means of support for patients, their carers and other health care professionals. The Marie Curie hospice in Cardiff is working collaboratively with other organisations to extend support and advice beyond its usual patient population 24 hours a day seven days a week.

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CHALLENGES OF CLINICAL CODING: AN AUDIT OF THE ACCURACY OF PRIMARY DIAGNOSIS CODING IN A SPECIALIST PALLIATIVE CARE UNIT

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Background Robust data collection regarding diagnoses of those referred to supportive and palliative care services is essential. It enables constructive dialogue between provider and stakeholders, supports service planning and delivery, and identifies trends in clinical conditions. With increasing age and multi-morbidity, data collection is increasingly challenging. This audit aimed to look at the accuracy of data collection within a single hospice.

Methods This was a retrospective audit of eighty patient notes. An audit proforma was developed to collect data relating to demographics, diagnosis, and comorbidities. The ICD-10 diagnostic code for each patient was extracted from the electronic data information system. The agreed standard was 100% of ICD-10 diagnostic codes should match primary diagnosis.

Results 61% of notes showed congruence between primary diagnosis and ICD-10 diagnostic code recorded. Of those notes showing discrepancy, 4 had no ICD-10 code recorded; 2 did not easily fit within ICD-10 codes available; 3 had multiple malignancy and immediate life limiting malignancy was incorrectly identified; 5 had the incorrect non-malignant diagnosis selected; and 1 was incorrectly recorded as having a non-malignant diagnosis. 63% of patients had a primary diagnosis of malignancy.