At our hospital local audit and observed practices identified that individualised care plans were not consistently shaped around the Five Priorities for care.1 We devised a change in clinical practice, developing an approach to individualised care planning and regular proactive symptom assessment for patients in the last days of life. A ‘Guide to individualised care planning in the last days of life’ was developed, whilst a ‘Symptom Observation Chart’ (SOC) was adapted with permission.2 The initiatives were piloted and successfully embedded on an Acute Admission Ward and then cascaded across elderly care and oncology, haematology, surgical oncology, renal and renal transplant wards.

SOCs were audited to ensure the adherence to record keeping, observation frequency and management and escalation recommendations. Nursing care plans were audited to ensure that at least 1 care plan was structured around the Five Priorities for care every 12 hours. 33 SOC’s were audited. 946 active symptoms recorded. When a PRN medication was required, management standards (medication given in <30 mins) were adhered to on 61% of occasions. On 51 occasions a symptom did not improve after a single PRN medication. On 36% of occasions, escalation standards were adhered to and a doctor/palliative nurse was informed. The standard of staff completing at least 1 nursing care plan structured around the Five Priorities for care every 12 hours, was not met consistently.

The audit highlights the challenges of implementing a change in clinical practice. Further education is required. Non-medical interventions are an important component of symptom management (71% of active symptoms recorded were managed without medication).

REFERENCES

A significant portion of patients whose intensive treatment is withdrawn or withheld whilst being in the Critical Care Unit (CCU) do not die imminently, rather they can survive up to several days and even weeks. Thus, they are usually discharged to the ward setting where their care is managed by general medical teams and are made ‘Not for readmission to CCU’.

The Specialist Palliative Care Treatment (SPCT) at our hospital noted that this patient group frequently requires intensive palliative care support but referrals to SPCT are only made when patients are imminently dying or not made at all. It was felt that the input of the SPCT at the point of CCU discharge for these patients could improve patients’ experiences, by prompting reassessment of treatment plans, and promoting the importance of the patient’s wishes.

An audit for all patients discharged from CCU with the Treatment Escalation Plan (TEP) ‘Not for readmission to CCU’ found that CCU was referring only 14% of patients with this TEP to SPCT, despite the fact that 75% of them died within that admission.

We undertook an education programme of CCU and outreach team and gradually implemented a policy of automatic referral to palliative care of all patients discharged from Critical Care with the TEP ‘Not for readmission to CCU’.

After several PDSA cycles over 6 months a 100% referral rate to SPCT from CCU for this group of patients was achieved. Our next step is to investigate whether or not this is improving patient outcomes.