

28 DELIVERING INDIVIDUALISED END OF LIFE CARE ON ONCOLOGY, HAEMATOLOGY, SURGICAL ONCOLOGY, RENAL AND RENAL TRANSPLANT WARDS: AUDITING THE IMPLEMENTATION OF A SYMPTOM OBSERVATION CHART AND GUIDE TO INDIVIDUALISED CARE PLANNING

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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

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29 INCREASING THE NUMBER OF REFERRALS TO THE HOSPITAL PALLIATIVE CARE TEAM OF PATIENTS WHO ARE DISCHARGED FROM CRITICAL CARE WITH A TREATMENT ESCALATION PLAN 'NOT FOR READMISSION TO CRITICAL CARE'

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A significant portion of patients whose intensive treatment is withdrawn or withheld whilst being in the Critical Care Unit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.

30 BRIDGING THE GAP

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There has been a recent drive to make palliative care more accessible to people from all communities and backgrounds with two of the core ambitions in the national framework for palliative and end of life care promoting equality and inclusivity.¹ Stemming from the ideals of these ambitions an educational initiative called Bridging the Gap was established in a district general hospital in London to improve communication and decision making between medical staff and their highly diverse patient population, in the important conversations that are had in end of life care.

Through workshops and hospital experience days we introduced to various Christian and Jewish leaders in the local community, the moral and ethical considerations that doctors and other medical staff face when they make decisions for deteriorating patients who are approaching the end of their lives. Qualitative feedback indicated a significant improvement in confidence and familiarity towards these topics among these leaders and that there was scope to reach out to the wider public within these groups. Future workshops and meetings need to be conducted to establish contact with other cultural and religious leaders in the local area.

At the same time we raised awareness of certain cultural, religious and spiritual perspectives towards end of life care among medical staff by conducting a hospital wide workshop. Perspectives that were explored were the Greek, African (general and subcultural) and Muslim perspectives. Feedback suggested that the workshop was a significant success but that there was a need for other perspectives to be explored.