

BACKGROUND AND INTRODUCTION

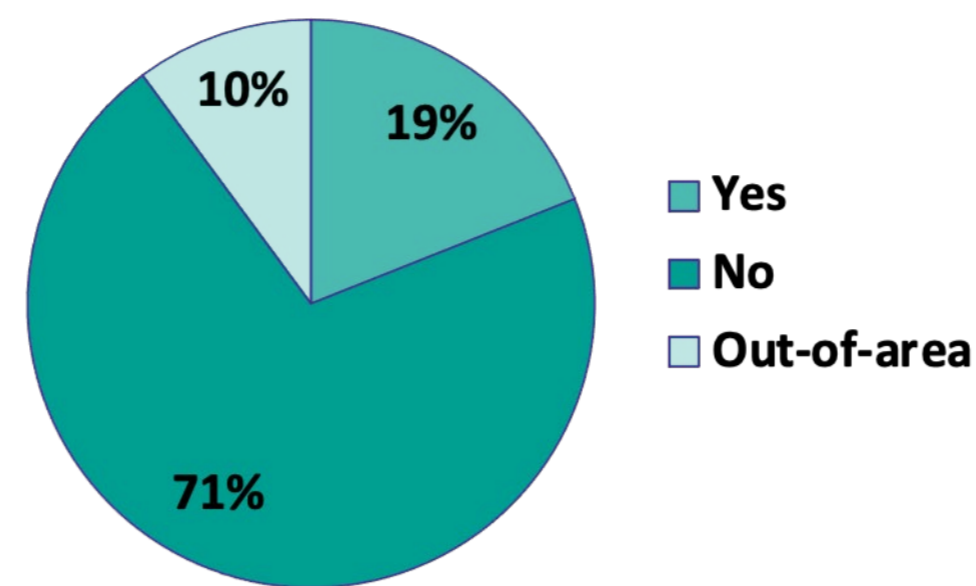
Evidence shows that good Advance Care Planning (ACP) with shared access improves patients' and their carers' experience of end-of-life care (EoLC). This includes a higher percentage achieving a preferred place of care and preferred place of death (1).

Coordinate My Care (CMC) is an electronic Palliative Care Coordination System (ePaCCS), containing important information about a patient's advance care plans. These records are seldom accessed in secondary care, despite increasing numbers being created in the community, particularly during the pandemic (2). This is responsible for inappropriate admission, inappropriate interventions as well as lengthening hospital stay where patients wishes are not acknowledged (3). In St Helier Hospital over a three-day period, 19% of admissions over 65 had an available electronic ACP record that was not accessed (Figure 1).

Good management of frailty requires a Comprehensive Geriatric Assessment (CGA) during an acute deterioration, which includes ACP where appropriate.

During the pandemic, an acute frailty ward was established in a previous escalation ward. The multidisciplinary team (MDT) included a consultant, a registrar, therapists, nurse specialist and an interface GP.

FIGURE 1: ED admissions of >65yo on 17-19 Feb 2021; Did the patient have a CMC record? (n=79)



AIMS AND OBJECTIVES

The MDT on the frailty ward was largely unaware that electronic ACP records existed or how to access these records. Going forward, our specific improvement goals are to:

1. Increase awareness of and facilitate access to existing ACP records and to incorporate this into decision making.
2. Facilitate and support good ACP discussions.
3. Provide training around creating electronic ACP records based on decisions during the current patient stay to be shared across settings.

METHODOLOGY

This is a largely descriptive service improvement project based in the acute frailty ward at St Helier Hospital. Data was obtained from electronic health records (trust records, CMC).

Groups engaged: The acute frailty ward team, palliative care, ED team, acute medicine division, IT, data quality team, service improvement team, CCG EoLC strategy group, primary care networks (PCNs).

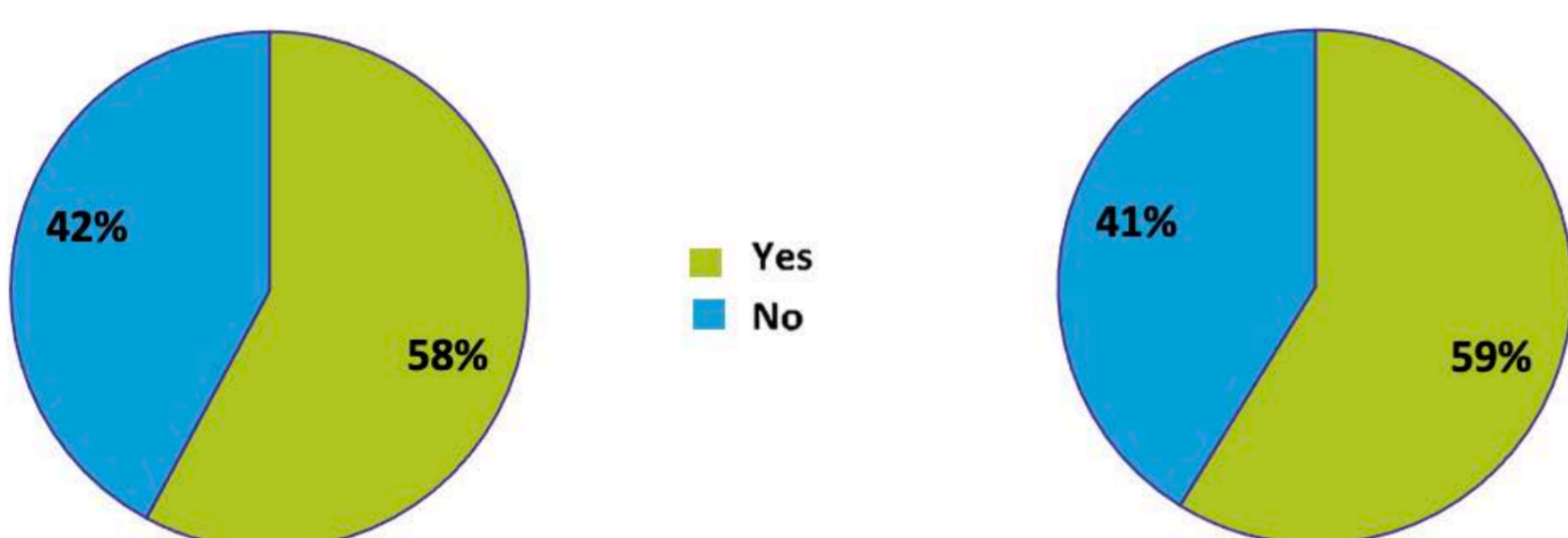
Impact measurement: Number of CMC logins, baseline and post-intervention frailty scoring.

Interventions and implementation:

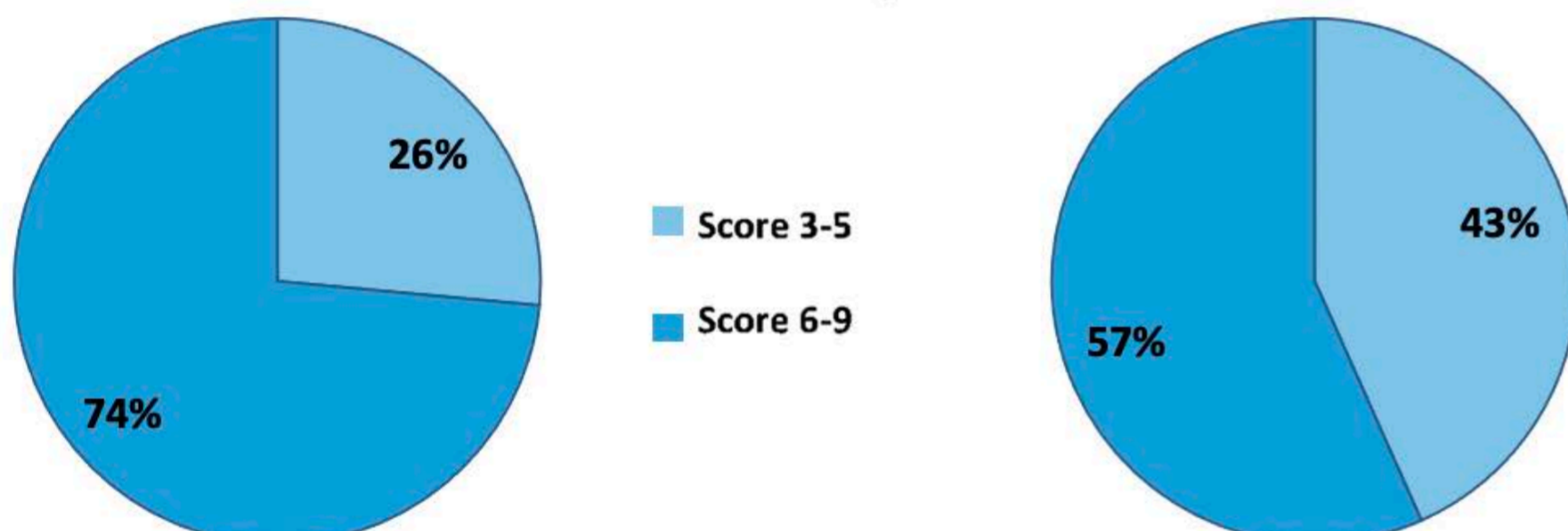
In February, an interface GP contributed to the introduction of an MDT handover on the frailty ward, including alerts for ACP records and required demographics. In March, she provided programmed and ad-hoc ACP training sessions to the team, which included support for staff CMC logins. The interface GP was present on the ward twice-weekly for immediate live access and support, and attended the MDT meetings.

FIGURE 2: >65yo admitted to the frailty ward before and after the intervention Feb 21 (n=57) April 21 (n=51)

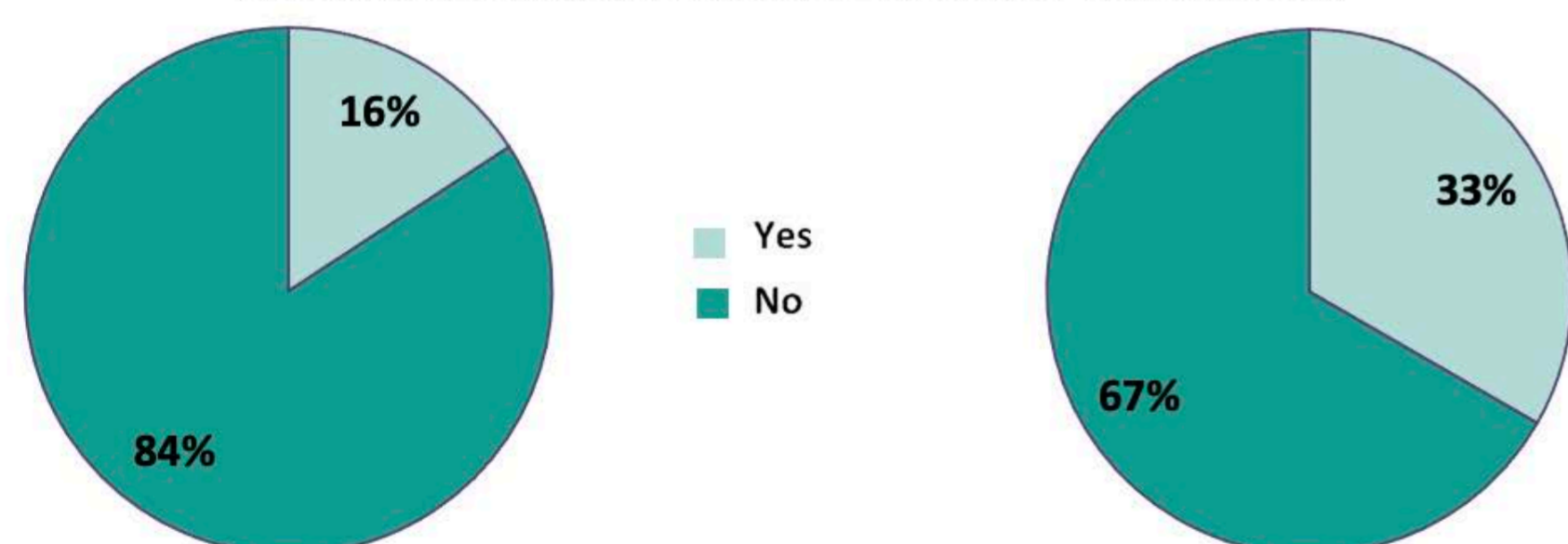
Was there a frailty score completed during the current hospital admission?



What was the frailty score?



Did the patient have an existing electronic ACP (CMC) record?



FINDINGS

MDT Handover

Following the introduction of the MDT handover which included pull-through CMC data, feedback from the frailty team suggested considerable interest in incorporating ACP into decision making.

Number of CMC Logins

Over the course of the intervention period (February-April 2021), 11 new CMC logins were created on the frailty ward in St Helier Hospital: 10 clinical and one administrative.

Frailty scoring in February and April 2021 (Figure 2)

In February, 57 patients aged over 65 were admitted to the frailty ward; 33 of these had a clinical frailty score recorded (58%) and the majority of these were deemed very frail (25 patients had a score of 6-9). Of the admissions, nine patients (16%) had an existing ACP record.

In April there were 51 admissions of over 65s to the frailty ward; 30 had a clinical frailty score recorded (59%) and just over half were deemed very frail (17 patients had a score of 6-9). A greater proportion of patients had an existing ACP record (17 patients, 33%)

There is no statistically significant difference in the number of patients receiving a frailty score during acute admissions between February and April 2021. There are a high proportion of over 65s who were severely frail (66% on average), yet across the months less than 25% of patients have an existing electronic CMC record. This highlights there is a need to recognise frailty and to have good ACP discussions on the frailty ward, and across the trust.

Case studies

In March, a patient with advanced dementia and recurrent aspirations was assessed by the frailty MDT and an agreement was reached with the family that there was nothing reversible and her needs could be best met at home, with full palliative support. CMC record prevented an inappropriate emergency re-admission at end of life.

In April, a 96-year old with moderate frailty was seen in hospital following a fall with full capacity. He wished to go home under any circumstances despite inadequate care support. ACP discussions were had with the patient and family and recorded. Community review at home found the patient was rapidly deteriorating with pneumonia on the following day. Decisions were confirmed and patient was supported in the next few days with full symptom management at home to end of life.

DISCUSSION OF LIMITATIONS

Consistent and recurrent face-to-face presence of an ACP champion in clinical areas is necessary to sustain the program. This is because during the intervention, it was noted a rapid rotation of staff on the frailty ward limited the progress made.

The project has been commenced during the pandemic, which has meant training was rescheduled continuously and the frailty ward- as a novel pathway- was undergoing many changes throughout. Reflective time was very limited.

The trust covers an area such that it uses both the ePaCCS and paper-based ACP records (ReSPECT), which is a challenge in itself to ACP service improvement strategies. Moreover, the CMC alerts within the trust were found to be inaccurate: the trust system failed to flag some existing records. This could undermine HCPs' trust in the alert system.

Data collection in the early days of the project was labour-intensive prior to accessing support from the data management team.

REFERENCES

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CONCLUSION AND IMPLICATIONS

Our findings show that in-person informal and formal interventions with HCPs increases awareness of the value of electronic ACP system. A more sustainable system would be if the training were to be incorporate into induction training, ideally to all HCPs and relevant administrative staff.

Feedback from a range of clinicians suggested there is considerable interest in incorporating ACP into decision making - and much greater impact would be achieved- if the record were readily accessible.

Evidence from elsewhere shows that quality of EoLC is improved with good ACP shared across settings, and this is likely to result in a shorter length of stay and reduced inappropriate admissions (3).

Within this trust, leadership around quality EoLC and ACP is emerging, with a coordinated approach with professionals in the community. Moreover, an ACP system is needed which integrates into a patient-centred CGA and electronic patient records.

We recommend a team-based multi-professional and multi-organisational approach to improving EoLC and ACP, which can start from quality improvement methodology, including repeated PDSA (plan, do, study, act) cycles.

ACKNOWLEDGEMENTS

This project was supported by Health Innovation Network London (HIN). It is a part of wider project around re-commissioning of the electronic palliative care coordination system (ePaCCS).