Improving the impact of CMC records for patients at The Hillingdon Hospitals NHS Foundation Trust during Spring 2021

L Bunker, M Troup, L Bainbridge, M House, J Potter
Hillingdon Hospital, Uxbridge, UK

Background

The Hillingdon Hospitals Trust (THH) is an acute and specialist services provider in North West London, serving the residents of the London Borough of Hillingdon and beyond (pop. 350,000).

Most reviews of Coordinate My Care (CMC) records in the Trust to date have been undertaken by the hospital palliative care team, for patients already on its caseload. There is little visibility of CMC records for patients who attend the Emergency Department (ED) or are admitted but not referred to the palliative care team. Patients with a CMC record who attend the Trust but do not necessarily need palliative care team input do still need their attending teams to be aware that they have pre-recorded preferences for care and ceilings of treatment.

The palliative care team has taken charge of this project, which largely aims to increase cross-team awareness of and engagement with CMC records for patients presenting acutely.

Introduction

Whilst the total CMC records created for Hillingdon residents is one of the highest in London, these records are largely invisible to hospital staff.

Because of this, the care and management of patients in ED and inpatient wards can be at odds with the preferences and ceilings of treatment set out in CMC. Additionally, community teams involved with these patients' care know very little clinical information post-patient discharge from ED.

Improving the awareness and visibility of CMC in the hospital and the flow of information out to community teams will improve patient-centred care, including reducing the frequency of ED attendance, inappropriate admissions and length of stay.

We set the following project goals:

1. Improve general visibility and awareness of CMC across generic teams by developing a THH-specific CMC Patient Information Leaflet and Advance Care Planning and CMC slide set, to use in various settings including rolling Trust medical inductions and small group teach with COTE, IMT, etc.
2. Improve visibility, awareness and impact of individual CMC records by prompting teams to use recorded preferences to guide care, management and optimum length of inpatient stay.
3. Improve collection and flow of Advance Care Plan (ACP)-relevant information across settings by reviewing case notes (accessed on Mediviewer electronic system) of patients with a CMC record who attend ED and are discharged home, and giving clinical updates to community teams where appropriate. This also involves prompting generic teams to update CMC records as appropriate and use the ACP fields on hospital discharge summaries.

Methods

The team developed a driver diagram to describe the process and specific actions needed to improve CMC impact across the trust. Some major required changes include:

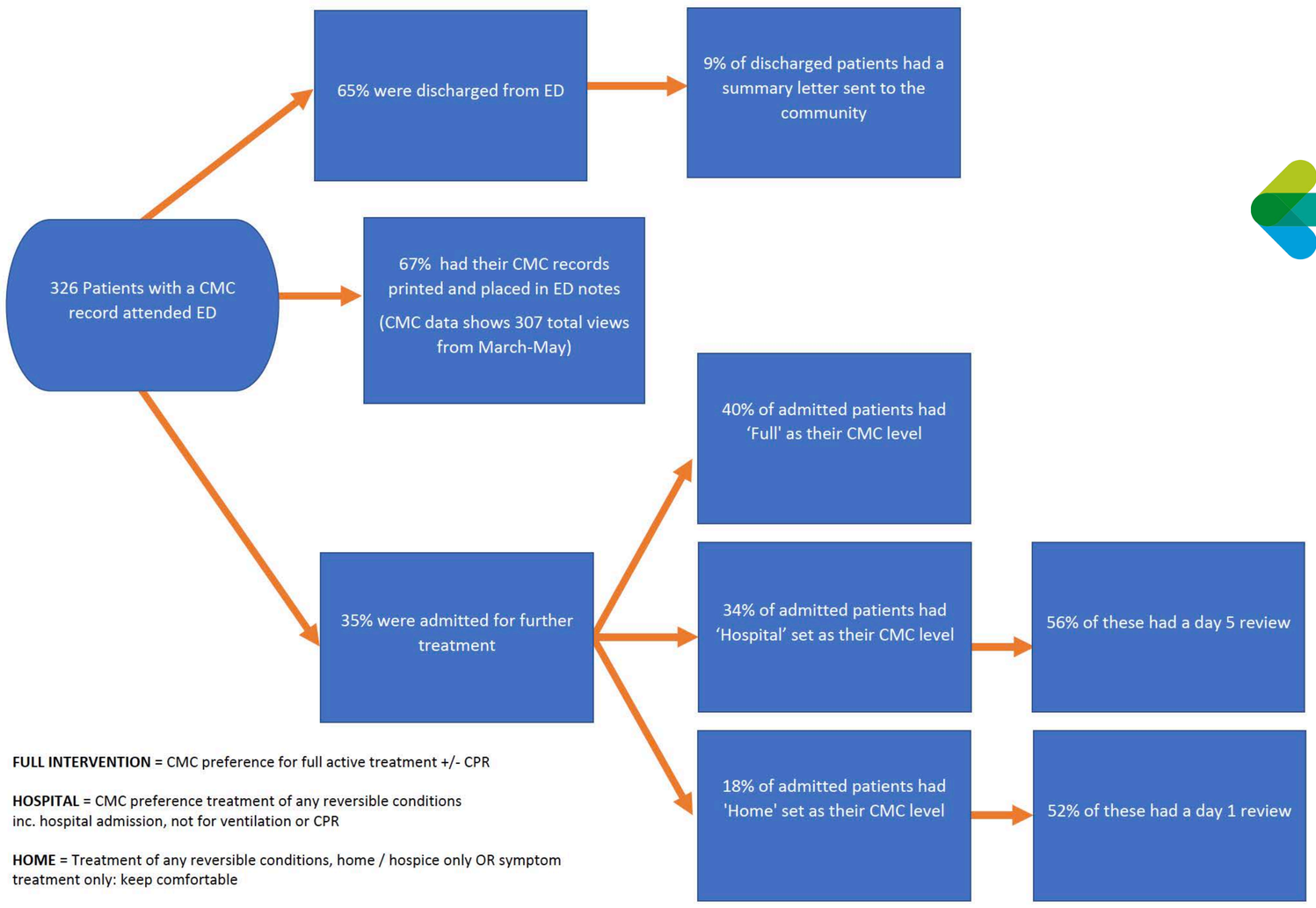
1. Ensuring ED admin staff print CMC records for patients who attend ED.
2. Creating a database of all patients with a CMC record.
3. Undertaking Day One and Day Five reviews of ED-admitted patients with a CMC record.
4. Undertaking case note reviews of ED attenders and liaising with community teams as necessary.
5. Pausing the project during the second wave of the pandemic and restarting with a more focussed project with a significantly smaller workforce.
6. Negotiating successfully for more time to teach about CMC during mandatory medical induction.

We set up a system that makes patients' CMC records visible to ED staff.

- Each week, Royal Marsden Hospital (RMH) sends an update of all new Hillingdon patients who have an ACP uploaded onto CMC to the THH records team.
- THH records team adds a 'CMC' flag onto the patients' THH electronic record.
- The flag is seen by staff when any of these patients attend ED, both electronically and on the paper cas card.
- The ED admin staff, on seeing the flag, access CMC site and print out the CMC summary and DNACPR form (if completed) on purple paper and add this to the cas card for the clinical team to see.

For THH-admitted patients with a CMC record, we set up a process to liaise with and support medical teams and patients so that this record guides care and management.

- Each working day, the palliative care team reviews the CMC record of each patient who was admitted the previous day (or days if a Monday)
- For each admitted patient whose CMC record states 'HOME', the Palliative Care Team undertakes a Day One assessment. For each patient whose CMC record states 'HOSPITAL', the Palliative Care Team undertakes a Day Five assessment. At either point, this assessment consists of a Level One ward review and liaison with medical team. This leads to agreement about most appropriate management plan, which may include rapid discharge home, accepting the patient on to the palliative care team caseload for further care or referring to discharge team for further liaison with medical team to aid discharge.



Results

From 16 March 2021 - 14 May 2021 – see flowchart to the left for data.

A CMC patient leaflet was successfully created and uploaded to Trust Internet and Intranet pages.

An end-of-life-care slide set containing CMC-related teaching was created for mandatory medical induction.

- This project has demonstrated that by setting up efficient systems, the palliative care team can continue engaging with CMC Day One and Five reviews (it has become business as usual).
- The Day One and Five reviews have led to cases of more patient-centred care - patients have been discharged more quickly, have had more appropriate levels of intervention and have had more liaison with community teams on discharge.
- Generic teams have begun to undertake their own CMC-centred reviews.
- Trust discharge team is positively engaging in cases to help expedite discharge.
- Feedback from community and hospital teams has been positive.

Conclusions

Prior to this project, an electronic tag system (to alert teams of a CMC record) was already in place. Following project interventions, each patient's CMC record is now printed out, and teams are directly engaged in considering patients' preferences and ceilings of treatment. This project has demonstrated that there are many patients who are likely in the last months to year of life to need ED and inpatient teams to be aware of their preferences and ceilings of treatment, even if they don't need direct palliative care input.