Advance care planning in those patients in their last year of life

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Aims

To identify those patients on a general and old age medicine ward who met the gold standard framework (GSF) criteria¹. Take these patients records and look at documentation regarding advanced care planning and whether this was communicated on the discharge summary.

Method

1. Initial data collection: retrospective, patients discharged from the ward that met the GSF criteria March to May 2014. Age, gender, medical condition, documentation in the patient notes, documentation on discharge summary and escalation documentation.
2. Implement change: ward round proforma, OPAL, frailty score² trust wide, education to juniors (discharge summary).

Results

2014 - mean age 83.3yrs (69-98), 15 male/ 19 female, average number of hospital admissions in the last year 1.6 (0-4).
2015 - mean age 84yrs (63- 94), 10 male/ 12 female, average number of hospital admissions in the last year 2 (0-7).

Below illustrates the percentage of patients with frailty scores and escalation status documented in their notes.

Audit Standards

1. Documentation in the patient medical records regarding future care plans (aim 100%)

2. Documentation on the discharge summary regarding future care consideration (aim 100%)

Conclusion

We have shown with simple measures (including; a ward round proforma, an old persons assessment team at the front door and a frailty CQUIN target due to be implemented in the trust) that our future care planning has improved between the two audits. There is still room for further improvement especially in regards to hospital admission avoidance.

References