Empowering the Acute Medicine Unit Multidisciplinary Team to Transform End of Life Care

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Introduction:
When asked about preferred place of death, 81% people want to die at home, 8% in a hospice, 7% in a care home and 3% in a hospital. However, the location of death is almost opposite: in England in 2016, 24% people died at home, 6% in a hospice, 22% in a care home and 47% hospital. These figures are worse in London. Nearly 500,000 people die in England/year. Of these, 80% are admitted to hospital at least once during the last year of life (LYOL) and ~33% of all hospital inpatients at any time are in the LYOL. Of those who die in hospital, 25% are there for over a month. As the population ages, these numbers are expected to rise. Inpatient end of life care (EOLC) is more expensive than in the community.

Advance care planning (ACP) - thinking about and planning for the future - improves EOLC, reduces hospital days in the LYOL and increases the % of those who die in their preferred place. It is known that 77% of people would want to know if they were in their LYOL yet only 10% of patients report having these conversations with their healthcare teams.

End of Life care at UCLH in 2017/18:
- 10.1% of all non-elective admissions were for patients within the LYOL (5,149). Of these, 48% were within the last 100 days of life.
- 815 inpatients died and Specialist Palliative Care were involved with - one third of these. Thus, non-palliative teams provided care to the majority of those who died.
- 33.1% of patients discharged from AMU in the last 100 days of life were readmitted within 30 days. This was higher than the Trust-wide average of 29.8%.
- 23.8% of patients in their LYOL were readmitted 2 or more times.

The Transforming End of Life Care Team:
In 2013, EOLC became a Trust Top 10 objective. The Transforming End of Life Care (TEOLC) Team of junior medical and nursing facilitators was formed to develop tools and provide training to staff delivering EOLC with leadership and Board oversight.
In 2018, TEOLC received UCLH Charity funding to expand in to the Acute Medical Unit (AMU) to improve end of life care and reduce hospital readmissions in the LYOL.

Aims:
To improve the identification and early discharge of patients on AMU likely to be in the LYOL.
To improve decision making and communication with those likely to be in the LYOL to reduce harm and distress.
To reduce hospital readmissions in the LYOL for patients discharged from AMU.

Methods:
From June 2018 – December 2019, a non-Palliative Care registrar and nurse facilitator from the TEOLC team integrated with the AMU multidisciplinary team (MDT) by:
- Attending morning and afternoon board rounds three days/week to identify and highlight patients who might be in the LYOL using the Supporting and Palliative Care Indicators (SPICT) tool and clinician intuition as surrogate markers.
- Supporting the MDT to have compassionate conversations and deliver high quality care to patients including the use of treatment escalation planning (TEP), advance care planning (ACP) and care in the last days of life.
- Supporting the MDT to create holistic discharge plans and ensure these are shared with primary care and community teams.
- Delivering fortnightly EOLC teaching to the MDT.

Results: TEOLEC team workload
~6000 AMU inpatients were screened and 1400 (23%) were identified and highlighted as likely to be in the LYOL.
TEOLC were directly involved in the care of 204 patients:

Results: Decision making and confidence
Completion of treatment escalation plan (TEP) documentation for all patients increased from 56% to 69% and correct completion of DNACPR paperwork from 33% to 76%.
The improved consideration and planning for potential deterioration was reflected in a 142 day period where there were no cardiac arrest calls to the AMU with no change in the total number of deaths. 75-86% of AMU staff reported feeling confident or very confident discussing LYOL with patients and relatives compared to 67-73% across the Trust.

Results: Readmissions in last 100 days of life
The TEOLC team substantially decreased 30 day readmissions for patients discharged in the last 100 days of life.

Discussion:
Acute Medicine needs to focus on the care of those who might be in the LYOL.
The AMU is an ideal arena to recognise these patients. Identifying such patients improves decision making and reduces harm through inappropriate over-treatment and resuscitation attempts.
Focussing on compassionate conversations to explore understanding, needs and wishes, to plan for future deterioration through the use of TEP and DNACPR documentation where appropriate, and to liaise with community based teams including referral to Community Palliative Care services has a profound effect on emergency readmissions and thus the cost of caring for people in the LYOL.
These effects can be achieved from within the AMU MDT without the need of Specialist Palliative Care practitioners but requires AMU team engagement and leadership as well as a team member to champion EOLC.