A Quality Improvement approach to improving Anticipatory Care Planning & Key Information Summary access at St John's Hospital

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Marie Curie — Care and support through terminal illness

Introduction

- Anticipatory Care Planning (ACP) is vital to ascertain patient preferences at the end of life and to avoid unnecessary and unwanted interventions.
- The electronic Key Information System (KIS) is a communication tool that conveys ACP information from Primary Care to OOH services.
- The KIS is now readily available to access in secondary care, but little is known about its use and whether the ACP information contained is useful in this setting.

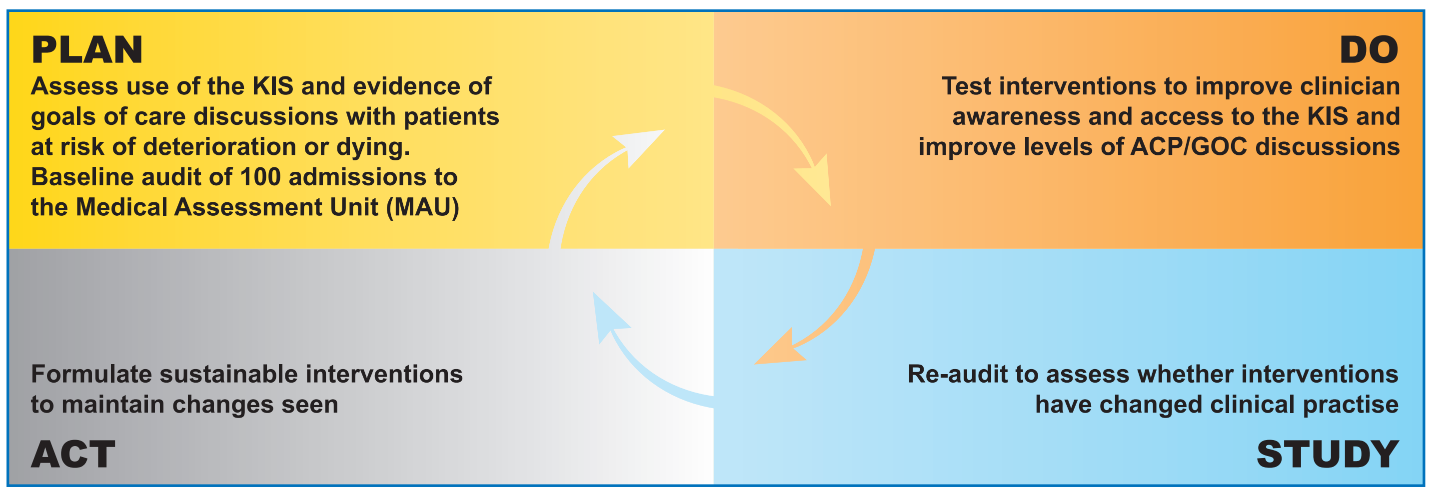
Aims

- Using validated IHI quality improvement (QI) methodology ***(PLAN, DO, STUDY, ACT)***, this project aimed to improve ACP awareness and 'Goals of Care' (GOC) conversations in a secondary care setting by:
  1. Increasing access to existing KIS information.
  2. Increasing the identification of patients with supportive and palliative care needs and subsequent GOC/ACP discussions.

Methods

- MAU admission case note audits (baseline n=100 and re-audit n=66).
- 16 one-to-one structured interviews with admitting clinicians (FY2 to consultant level) to ascertain views on usefulness of KIS.

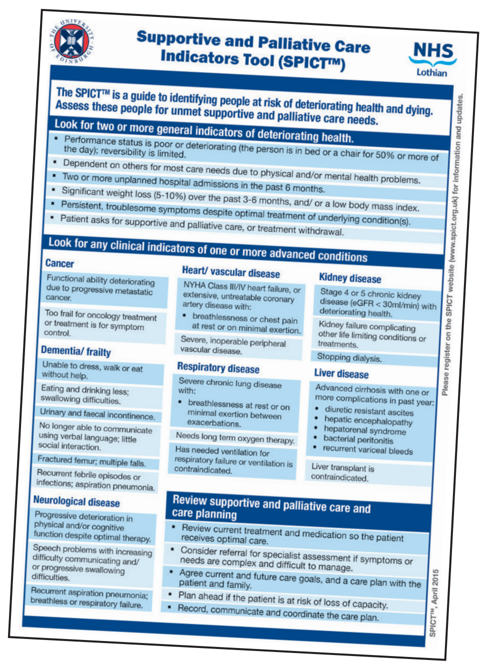
Figure 1: ***PLAN, DO, STUDY, ACT***



Results

Initial results ('Plan' stage)

- 24% of all patients admitted to MAU had a KIS.
- 53% of patients at risk of deteriorating or dying (using SPICT™) had a KIS.
- 67% of KIS contained a 'Special Note' (contains ACP information).
- Two forms of KIS are available electronically:
  1. The 'abbreviated' KIS (attached to Electronic Care Summary (ECS) Medications list). **Accessed in 89% of admissions, but only 19% of admitting clinicians had seen the KIS for their patient.**
  2. The 'full' KIS document was **accessed in 1 case only where a KIS was available (4%).**
- **75% of admitting clinicians interviewed thought the KIS was useful.** The main reason they had not seen the KIS was lack of awareness.
- **In 19% of cases the KIS would have changed clinical management.**
- There was little evidence of Goals of Care discussions during the first 48 hours of admission for patients at risk of deterioration or dying, Table 2.


Supportive and Palliative Care Indicators Tool (SPICT™) — NHS Lothian

The SPICT™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.
- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day); reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition(s).
- Patient asks for supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more advanced conditions

Cancer: Functional ability deteriorating due to progressive metastatic cancer. Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty: Unable to dress, walk or eat without help. Eating and drinking less; swallowing difficulties. Urinary and faecal incontinence. No longer able to communicate using verbal language; little social interaction. Fractured femur; multiple falls. Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease: Progressive deterioration in physical and/or cognitive function despite optimal therapy. Speech problems with increasing difficulty communicating and/ or progressive swallowing difficulties. Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease: NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with: breathlessness or chest pain at rest or on minimal exertion. Severe, inoperable peripheral vascular disease.

Respiratory disease: Severe chronic lung disease with: breathlessness at rest or on minimal exertion between exacerbations. Needs long term oxygen therapy. Has needed ventilation for respiratory failure or ventilation is contraindicated.

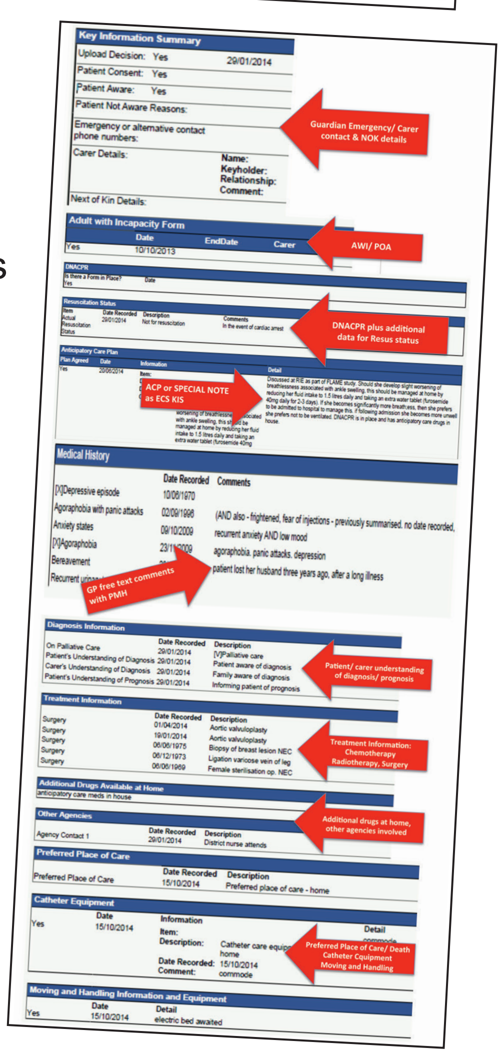
Kidney disease: Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health. Kidney failure complicating other life limiting conditions or treatments. Stopping dialysis.

Liver disease: Advanced cirrhosis with one or more complications in past year: diuretic resistant ascites; hepatic encephalopathy; hepatorenal syndrome; bacterial peritonitis; recurrent variceal bleeds. Liver transplant is contraindicated.

Review supportive and palliative care and care planning
- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2015


Key Information Summary

Upload Decision: Yes 29/01/2014
Patient Consent: Yes
Patient Aware: Yes
Patient Not Aware Reasons:
Emergency or alternative contact phone numbers:
Carer Details: Name: Keyholder: Relationship: Comment:
Next of Kin Details:

Adult with Incapacity Form — Date / EndDate / Carer — Yes 10/10/2013

DNACPR — Is there a Form in Place? Date — Yes

Resuscitation Status — Date Recorded 29/01/2014 — Not for resuscitation — In the event of cardiac arrest

Anticipatory Care Plan — Plan Agreed / Date / Information / Detail — Yes 28/06/2014

Medical History — Date Recorded / Comments
- [X]Depressive episode 10/06/1970
- Agoraphobia with panic attacks 02/09/1996 (AND also - frightened, fear of injections - previously summarised. no date recorded.
- Anxiety states 09/10/2009 recurrent anxiety AND low mood
- [X]Agoraphobia 23/11/2009 agoraphobia. panic attacks. depression
- Bereavement — patient lost her husband three years ago, after a long illness

Diagnosis Information — Date Recorded / Description
- On Palliative Care 29/01/2014 [V]Palliative care
- Patient's Understanding of Diagnosis 29/01/2014 Patient aware of diagnosis
- Carer's Understanding of Diagnosis 29/01/2014 Family aware of diagnosis
- Patient's Understanding of Prognosis 29/01/2014 Informing patient of prognosis

Treatment Information — Date Recorded / Description
- Surgery 01/04/2014 Aortic valvuloplasty
- Surgery 19/01/2014 Aortic valvuloplasty
- Surgery 06/06/1975 Biopsy of breast lesion NEC
- Surgery 06/12/1973 Ligation varicose vein of leg
- Surgery 06/06/1969 Female sterilisation op. NEC

Additional Drugs Available at Home — anticipatory care meds in house

Other Agencies — Agency Contact 1 — 29/01/2014 — District nurse attends

Preferred Place of Care — Preferred Place of Care 15/10/2014 Preferred place of care - home

Catheter Equipment — Yes 15/10/2014 — Description: Catheter care equip… home — Date Recorded: 15/10/2014 — Comment: commode

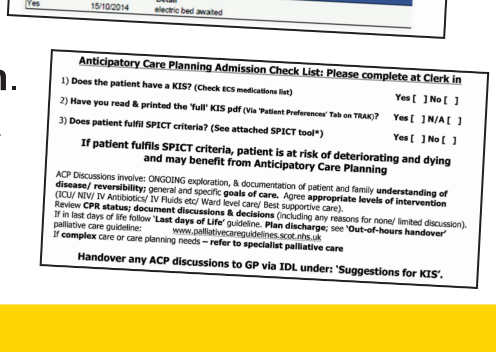
Moving and Handling Information and Equipment — Yes 15/10/2014 — electric bed awaited

Interventions ('Do' stage)

- Addition of an **ACP 'tab'** and **SPICT™ tool** to admissions documentation to prompt checking of KIS and identification of patients who may benefit from ACP discussions.
- **Education sessions** (medical meeting, ward based and informal).
- **KIS Posters** placed strategically to prompt and simplify KIS access.

Re-audit following Interventions ('Study' stage)

- **Completion of ACP tab and SPICT™ tool low** (31% and 20% respectively).
- Goals of Care discussions – **Interventions did not significantly increase GOC discussions within 48h.**
- On the re-audit, it was possible to study whether GOC discussions occurred later during the admission. This revealed that **certain aspects of ACP are discussed earlier, and some closer to discharge,** Table 2.


Anticipatory Care Planning Admission Check List: Please complete at Clerk in

1) Does the patient have a KIS? (Check ECS medications list) Yes [ ] No [ ]
2) Have you read & printed the 'full' KIS pdf (Via 'Patient Preferences' Tab on TRAK)? Yes [ ] N/A [ ]
3) Does patient fulfil SPICT criteria? (See attached SPICT tool*) Yes [ ] No [ ]

If patient fulfils SPICT criteria, patient is at risk of deteriorating and dying and may benefit from Anticipatory Care Planning

ACP Discussions involve: ONGOING exploration, & documentation of patient and family **understanding of disease/ reversibility;** general and specific **goals of care.** Agree **appropriate levels of intervention** (ICU/ NIV/ IV Antibiotics/ IV Fluids etc/ Ward level care/ Best supportive care). Review **CPR status; document discussions & decisions** (including any reasons for none/ limited discussion). If in last days of life follow '**Last days of Life**' guideline. **Plan discharge;** see '**Out-of-hours handover**' palliative care guideline: www.palliativecareguidelines.scot.nhs.uk
If **complex** care or care planning needs – **refer to specialist palliative care**

Handover any ACP discussions to GP via IDL under: 'Suggestions for KIS'.

Table 1: ***Patients admitted to MAU with a KIS and changes in access to these KIS on admission following interventions***

	Baseline Audit 2014 Pre-interventions (%) (n=100)	Re-Audit 2015 Post-interventions (%) (n=66)
Patients admitted to MAU with a KIS	**27%**	**24%**
Access to ECS 'abbreviated' KIS	**89%**	**89%**
Access to 'Full' KIS	**4%**	**47%*****

Table 2: ***Documentation of Anticipatory Care Planning or 'Goals of Care' discussions held within 48h (pre & post intervention) as well as during remaining hospital admission (>48h)***

Goals of Care Discussion Criteria: Yellow denotes aspects most discussed closer to admission (within 48h). Green denotes aspects more likely to be discussed closer to discharge	Baseline Audit Oct 2014 Within 48h of admission (n=32)	Re-Audit Mar 2015 Within 48h of admission (n=23)	Re-Audit Mar 2015 More than 48hrs post admission (n=17)
Acknowledgment patient at risk of deterioration/dying	**34%**	**17%**	**6%**
Patient understanding of disease explored	**9%**	**13%**	**24%**
Family/carer understanding of disease explored/intention to do so documented	**47%**	**35%**	**53%**
Potential for reversibility of condition discussed/documented	**25%**	**26%**	**18%**
Uncertainty of recovery acknowledged	**9%**	**9%**	**18%**
Treatment outcomes discussed with patient	**3%**	**13%**	**24%**
"What matters" (Patient goals, expectations, concerns?) documented	**0%**	**4%**	**12%**
Preferred place of Care discussed with patient/family	**13%**	**9%**	**18%**
Information required assessed or given	**9%**	**0%**	**12%**
Appropriate levels of intervention documented	**13%**	**9%**	**6%**

Planned Interventions ('Act' Stage)

- **Further PDSA cycles** at St John's Hospital informed by focus groups to maintain engagement and ascertain which interventions are workable to maintain and improve the change in practise seen.
- Plan to **change the format of the KIS to one single 'full' KIS document** attached to the ECS medications list (this may improve access to the 'full' KIS data to almost 90%).
- **GP updates** at events to feed back the usefulness of their KIS and encourage ongoing good practise.

Conclusions

- **1 in 4 patients admitted to Acute Medicine are likely to have a KIS**.
- In this study, 53% of patients at risk of deterioration or dying had a KIS.
- Of those KIS seen, 2/3 include important ACP information in the form of a 'Special Note' or 'ACP comment'.
- Initial awareness of the KIS and access to the full version was low at SJH.
- **Using QI methodology at a ward level it is possible to significantly improve access to 'full' KIS ACP data (4%-47%).**
- 75% of clinicians interviewed thought the KIS for their patient was useful.
- **Improving secondary care access to KIS data for patients with complex and palliative care needs could affect patient management in around 1 in 5 patients.**
- **Different aspects of GOC discussions occur at different stages during the hospital admission. The SPICT™ tool may be more useful employed at a later stage of a patient's admission.**

Recommendations

1) **Establishing the presence of a KIS needs to be embedded into the admission process.**
2) **Focus groups** to be held at other Lothian Hospitals re ways to improve ACP information access via KIS.
3) **Further audit and research** to explore ways of ensuring ACP conversations are communicated back to Primary Care.

NHS Lothian — Institute for Healthcare Improvement — Scottish Patient Safety Programme (Every Person Every Time)