Do Hospital Anticipatory Care Plans improve patient care?

An evaluation of end of life care in a District General Hospital

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Introduction

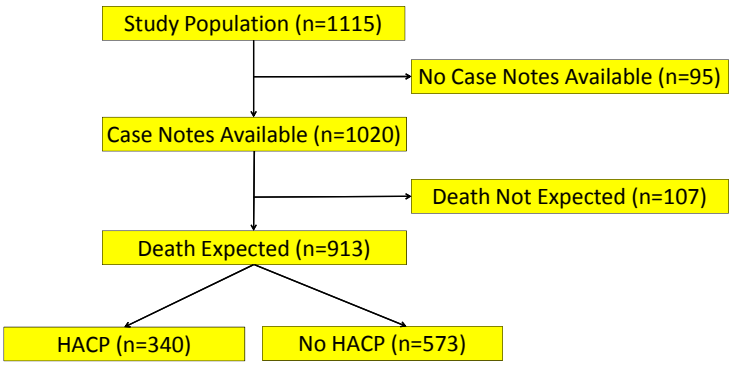
Anticipatory care planning at the end of life is a fundamental element of hospital inpatient care, with 1 in 10 hospital inpatients dying before discharge. [1] Patients often come to harm at the end of life in hospital due to non-beneficial treatments and investigations. [2] Effective communication is essential in order to reduce this harm.

All clinicians involved in caring for patients at the end of life have a responsibility to communicate key care goals and decisions with patients, their families and all members of the multi-disciplinary team involved in their journey. [3,4]

This study described the use of Hospital Anticipatory Care Plans (HACPs) as a communication tool and explored the effects of their use on patient care at the end of life.

Method

This was a retrospective review of all patient deaths in Hairmyres Hospital, East Kilbride, between 02/02/2016 and 02/02/2017. Patient deaths were identified as "expected" when death was likely in the next 12 months.[5] Study exclusion criteria included out of hospital cardiopulmonary arrest where no return of spontaneous circulation was achieved, and sudden unanticipated cardiopulmonary arrest within the hospital environment.[5] Subjects were categorised according to presence or absence of HACP at the time of death and relevant data was collected and analysed.



Results

Treatment Escalation/Limitation Decisions:

99.7% of patients in the HACP group had a defined treatment escalation/limitation decision in the case notes compared to 88.1% in the No HACP group. Presence of HACP in case notes at the time of death predicted a higher frequency of documented treatment escalation/limitation decisions ($p<0.05$).

DNACPR Decisions:

99.7% had a valid DNACPR document at the time of death in the HACP group, compared to 96.5% within the No HACP group. Presence of HACP predicted greater number of DNACPR documents within patient case notes at the time of death ($p<0.05$).

Communication of DNACPR Decisions:

	DNACPR & HACP (n=339)	DNACPR & No HACP (n=553)
Discussion with Patient	23.6%	19.9%
Discussion with Next of Kin	89.4%	81.9%
Discussion with Patient or Next of Kin	92.0%	84.6%

HACP predicted more frequent discussion of DNACPR decision with the patient's family or next of kin ($p<0.05$).

Anticipatory Prescribing:

Medication	HACP (n=340)	No HACP (n=573)
Mouthcare	14.7%	0.2%
Opiate	81.4%	64.5%
Anxiolytic	81.5%	61.4%
Anti-emetic	38.0%	25.3%
Anti-secretory	71.5%	52.5%
Anti-psychotic	7.6%	3.3%

HACP predicted greater frequency of anticipatory medication prescription as outlined in Scottish Palliative Care Guidelines.

Referral to Hospital Palliative Care:

23.5% patients in the HACP group were referred to Hospital Palliative Care services compared to 13.3% within the No HACP group ($p<0.05$).

Discussion

Within this hospital setting, HACPs are an effective clinical tool to improve patient care and communication of key decisions at the end of life. We would recommend initiation of HACPs for patients in whom death is expected within their hospital admission.

References:
1. Clark, D., Armstrong, M., Allan, A., Graham, F., Carnon, A. and Isles, C. (2014) Imminence of death among a national cohort of hospital inpatients: Prevalent cohort study. *Palliative Medicine*, 28(6), pp. 474-479. 2. Cardona-Morrell M, Kim JCH, Anstey M, Mitchell IA, Hillman K. (2016) Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem. 3. Fritz Z, Slowther A, Perkins G (2017) Resuscitation policy should focus on the patients, not the decision. 4. Decisions relating to Cardiopulmonary Resuscitation - 2016. 3rd edition. UK Resuscitation Council. 5. GMC guidance end of life care. 5. Treatment and care towards the end of life: Good practice in decision making. General Medical Council (2010)