Introduction and assessment of a structured specialist palliative care discharge letter

Kirsteen Shaw, Palliative Care CNS. Alistair McKeown, Consultant in Palliative Medicine.
Hospital Specialist Palliative Care Team, Queen Elizabeth University Hospital, Glasgow

Advance Care Planning (ACP) is a person centred, proactive approach to help patients, families and carers consider what is important to them and help plan for their care in the future.

Palliative Care Teams in hospital and hospice settings are often well placed to facilitate these plans and discussions,

Discharge letters from these units can help communicate important information and decisions to GPs and other Out of Hours services to help guide patient care.

Good quality letters highlight important complex aspects of care and advance care planning discussions which are essential for coordinated, collaborative patient care.

NHS Greater Glasgow and Clyde

MACMILLAN CANCER SUPPORT

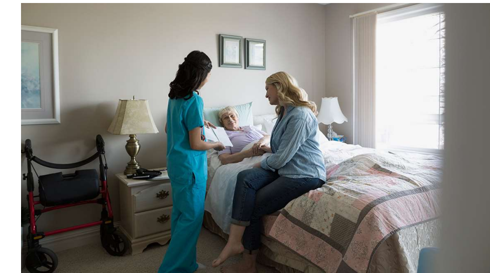
Kirsteen.Shaw@ggc.nhs.uk

This poster is part of the SPPC Poster Parade 2021

Scottish Partnership for Palliative Care

Aims

- To improve documentation and communication of important aspects of care including:
  - DNACPR decisions
  - Preferred Place of Death (PPOD)
  - Patient and family understanding of disease and prognosis
  - Treatment plan in event of deterioration (e.g. admission to hospice, home for end of life etc)
- To promote coordinated care and communication for patients, families and carers
- To try reduce admissions unwanted by patients.
- To prompt GPs to complete and update Key Information Summary (KIS) to further aid OOH communication



End user screenshot of KIS – A+E

Key Information Summary (KIS)		
Upload Decision:	Yes	21-Aug-2012
Patient Consent:	Yes	
Patient Aware:	Yes	
Special Patient Note:	01-Jan-2100	oCCASIONAL DETERIORATION IN HEALTH WITH POSSIBle vascular event. This has usually been relieved with increased fluids as possible and nursing care. Family aware that only for hospital treatment in extreme circumstances as will usually be of no advantage to patient
Medical History:		1. Type 2 diabetes mellitus (28-Jan-2000) 2. Anxiety states (01-Jan-1990) 3. Essential hypertension (27-Mar-2003) 4. Left ventricular failure (21-Aug-2006) 5. Cerebrovascular disease (01-Jan-1997) 6. Cirrhosis of liver NOS (21-Jun-2011 , Cause unknown) 7. [X]Vascular dementia (25-Jul-2011)
Anticipatory care plan agreed:	Yes	Has anticipatory care plan (07-Feb-2012)
Preferred Place of Care:		**Place** / **Description** / **Date** / **Comment** Preferred Place of Care / Preferred place of care - nursing home / 21-Aug-2012
Adult with incapacity form:	Yes	Incapacity (Scotland) Act 2000 certificate (07-Feb-2012)

NHS Greater Glasgow and Clyde

MACMILLAN CANCER SUPPORT

Kirsteen.Shaw@ggc.nhs.uk

Methods

30 Hospital Palliative Care and Hospice Discharge letters were reviewed in 2019, with analysis of content including presence of the DNACPR, PPOD, Treatment care plan in event of deterioration.

A working group of Palliative Care HCPs and GPs across GGC designed a new structured discharge letter template with agreement from all units.

This was implemented across multiple sites and a repeat review of letters from GRI and QEUH Palliative Care Teams was undertaken.

Specialist Palliative Care Team Discharge Letter

Please update the patient's KIS as per the below

This patient has consented to this information being shared electronically: Y/N		
Name:	**Title:**	
Address: **Tel no:**	**GP Details:**	
CHI /DOB:	**Admitted from: (Place, date)** **Discharged to: (Place, date)** **Date referred to Pall care team (if applicable)**	
Next of Kin/Main Carer: **(Details as required)**	**Contact Details:**	
Primary Diagnosis (Inc Date):	**Metastatic Disease:** (If applicable)	
Treatment to Date: (Primary diagnosis)		
PMHx **Comorbidities:**		
Patient awareness: (Diagnosis and prognosis)	Document patient understanding of disease, prognosis and ongoing care plans	
Family/carer awareness: (Diagnosis and prognosis)		
AWI/POA:	Yes/No	Details including capacity issues, POA, Guardianship, Living Will or NOK contact details if in place
Management Plan for Decline: (Please update special note for eKIS)	Information for community HCP re: plans in event of deterioration. e.g. comfort care, PO abx or admit acute	
Additional useful information for GP/OOH services:		
GP action required: (If appropriate)		
Resuscitation status: (With summary of discussion)		
Preferred Place of Care:		
Preferred Place of Death: (1st/2nd preferences/other wishes if appropriate)		
Portal ACP Document or other ACP updated:	Yes/No/NA – details and direction adapted to local practices (e.g. R specific ACP)	
Physical Assessment: (Include Performance Status or PPS Level)		
Social Assessment: (Inc. package of care, current care needs/support)		
Psychological Assessment:		
Spiritual Assessment:		

Medications/Ongoing follow up/special requirements

Discharge Medications	**Hospice letters only** **HSPCT letters – state "see ward IDL"**	
Changes to Medications	**Hospice letters only - stopped, started and rationale**	
Allergies:	**Hospice letters only unless specific information identified by Hospital Pall Care team (e.g. toxic on morphine)**	
Pacemaker/ICD:	Yes/No	State if deactivated/plans if appropriate
Pall Care follow up:	Hospice outpatient, Community Palliative Care, Other	
Other agencies involved:	e.g. District Nurses/Marie Curie Fast Track/Cordia	
Equipment/requirements	e.g. Hospital bed, oxygen, indwelling ascitic drain, intrathecal analgesia, just in case meds, Syringe pump, hoist	
Other requirements and information:	Free text/narrative as needed	
Palliative Care Contact if further info required	Name/Contact details as required	

The information has been provided in this format to facilitate creation/updating of an Electronic Palliative Care Summary/Key Information Summary (KIS)

Dictated by:
Dictated on:

Typed on:

NHS Greater Glasgow and Clyde

MACMILLAN CANCER SUPPORT

Kirsteen.Shaw@ggc.nhs.uk

Results and Conclusions

- 30 letters were reviewed in 2019 and then in 2020, after implementation of structured document
- Clear improvement in the content of letters was shown across a range of areas on both sites
- There was an increase in completed KIS and transfer of information from letters
- There was also an increase in patients achieving documented PPOD, although numbers were small
- The impact of the Covid-19 pandemic may have influenced some of the above
- Overall, the introduction of a structured SPCT discharge letter has greatly improved content of communication of ACP between hospital and community teams

GRI	DNACPR	PPOD	Care plans
2019	42%	32%	46%
2020	66%	46%	83%
QEUH			
2019	74%	35%	77%
2020	86%	83%	97%

Table 1: Documentation of information in discharge letter

NHS Greater Glasgow and Clyde

MACMILLAN CANCER SUPPORT

Kirsteen.Shaw@ggc.nhs.uk