

Place of Death: what are we documenting, and what are we achieving?

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Introduction

Once a patient has been identified as likely to benefit from Palliative and End of Life Care, it is important to ensure an adequate assessment of needs is undertaken and patient wishes are recognised. Patients under Specialist Palliative Care should have the opportunity to discuss their preferred choices (if appropriate) and efforts made to facilitate these whilst being reviewed regularly.

Unfortunately getting a patient to their preferred place of death (PPOD) is not always possible. This audit aimed to examine recording and achievement of PPOD in a Specialist Palliative Care Service.

Audit Clinical Standards

100% of patients known to Prince and Princess of Wales Hospice (PPWH) palliative care services should have a PPOD documented (or a reason why it was not discussed).

100% of patients known to PPWH should die in their preferred place of care (or have a documented reason why this was not possible).

Methodology

A representative, retrospective case note/portal review of 48 patients known to the PPWH was carried out.

Deaths between Jan 2014 - March 2014 were eligible and identified using board clinical activity statistics which records the number of deaths in each service per month.

A representative sample number for each service was chosen;

- 5 per month from IPU (n=18)
- 6 per month from the Community Service, 1 from each Nurse caseload (n=15),
- 3 per month for the Day Hospice (n=9)
- 2 per month for Outpatients (n=6)

Monthly data extraction spreadsheets were used to identify the Crosscare ID numbers of patients who had died within the eligible period in each service. From these ID numbers, a random sample was taken to meet the cohort size.

The relevant data was collected from Crosscare patient system and clinical Portal, then entered into a Microsoft Excel spreadsheet for data collection and analysis.

Results

Documentation of Preferred Place of Death

39 patients (81.25%) out of the 48 patient cohort had a recorded PPOD. Of the 9 patients (18.75%) without a discussed PPOD, 2 (4.17%) had a documented reason and 7 patients (14.58%) did not (Figure 1). The percentage documented varied by service (Figure 2).

Overall Percentage Recorded PPOD

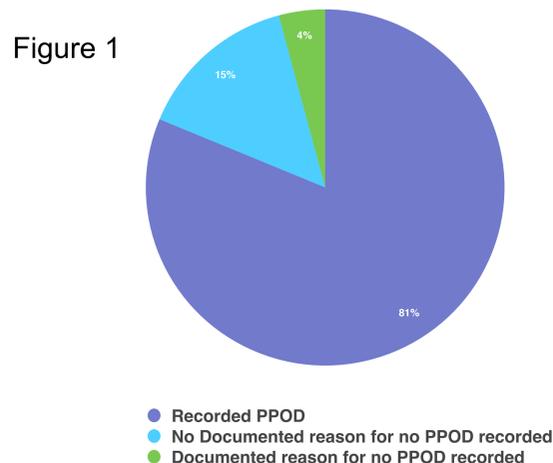


Figure 1

Recording of PPOD in each Hospice Service

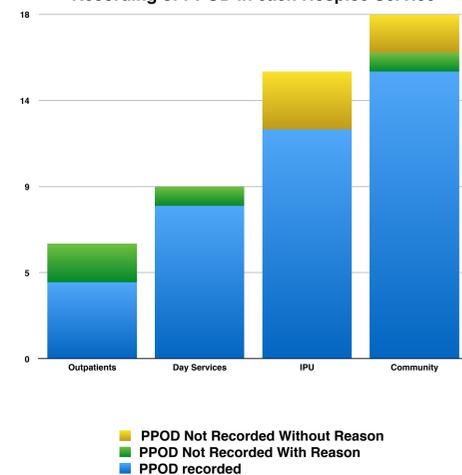


Figure 2

10 (25.64%) of the 39 patients with documented preferred place of care changed their preferences at least once while they were under specialist hospice services. Most of these (60%) changed their preferred place of death to "hospice" from another setting.

Achievement of Preferred Place of Death

Overall, 32 (82.05%) of the 39 patients with a documented preferred place of death achieved their stated goal. Again, there were variations by service (Table 1). The patients who did not achieve their PPOD (7 patients (17.95%)) all had a clear reason why (e.g. acute illness, no bed request made).

PPOD Outcomes in each Hospice Service

Service	PPOD achieved	PPOD not achieved	Total patients with PPOD recorded
Out-patient	2	2	4
Day Services	6	2	8
IPU	12	0	12
Community	12	3	15
Total	32	7	39

Table 1

Discussion

Day service and IPU user results show that 100% of patients had either their PPOD recorded or a reason for failing to record PPOD noted. This could be due to greater regular contact with patients, or a greater understanding of the inpatient hospice unit when compared to the users of other services.

Community and Outpatient users had PPOD fully recorded in the majority of cases but there were a number of patients missing documented PPOD without a reason clearly recorded. This may be due to limited discussion time, less exposure to inpatient services, or that these advanced care planning discussions may not yet have been felt appropriate.

The 60% who changed their PPOD to the Hospice may reflect progression of disease and a realisation that higher care levels were beneficial. Any further extrapolations would be difficult without more information on specific reasons behind a patients PPOD change.

The majority of patients died in their PPOD when it had been documented. It is encouraging that this was achieved in so many cases, but ongoing work to address the minority who do not reach this goal is required.

Conclusions

Feedback to the different hospice service groups on current levels of recording and achievement will be undertaken to promote and encourage improvements and maintenance of standards.

Advanced care planning and PPOD remains a challenging but integral part of a holistic palliative care assessment. Further work exploring the barriers to such discussions may be helpful, both with patients and health care professionals.