

Audit of documentation of end of life care in Geriatrics wards

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Introduction

Caring for dying patients is a significant part of the work of Geriatrics wards. The Liverpool Care Pathway (LCP) has been recommended as a framework for best practice at the end of life, both in UK national policy and in Living and Dying Well¹.

Biggart Hospital is a Care of the Elderly unit comprising of four assessment/rehab wards and two continuing care wards. This audit sought to determine whether the current provision of end of life care on our wards was satisfactory, and more specifically:

- whether all suitable patients in Geriatrics wards were being treated on the LCP
- whether care given was meeting the standards as set by the LCP

In order to ascertain this, the documentation of end of life care was assessed at three key times: recognition of dying, anticipatory prescribing and communication of care decisions with relatives and staff; ongoing care and regular assessments of symptoms; and care after death.

Methods

A retrospective casenote review of a three month period was performed, looking at expected deaths in our unit. 26 deaths were identified. Those who had an unexpected death or who were receiving active treatment up to their death were excluded. 18 remaining patients were included in the audit. Their casenotes were reviewed, with attention to both the medical and nursing notes.

Standards:

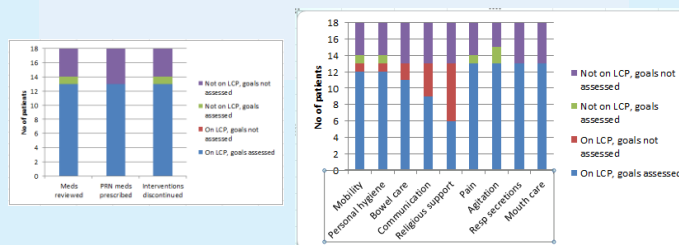
- All patients with end of life and palliative care needs should be cared for on the LCP
- All patients should have all palliative care goals assessed as per the LCP
- Goals should be met at least 85% of the time

Reference

1. Living and Dying Well: a national action plan for palliative and end of life care in Scotland (2008). The Scottish Government, Edinburgh.

Results

The majority of patients (13) had non-malignant conditions as the cause of death. Of the patients studied, 13 were on the LCP prior to death; all would have been appropriate for the LCP. Those on the LCP had better documentation of care. "Symptom goals" were well-documented. "Religious support" was most poorly documented. Post-death care was universally poorly documented.

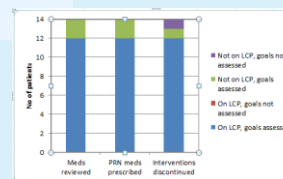


Conclusions

The uptake of the LCP in our unit was good, but could be improved. Assessment of "symptom goals" was generally well-documented. A limitation of the study was that actual care given may have been underestimated as a result of insufficient documentation.

The results were presented to medical staff, and a meeting was held with nursing staff to discuss how the uptake of the LCP could be improved. Nursing and medical staff both reported difficulties regarding the initiation of the LCP.

Nursing staff felt that doctors were often reluctant to start people on the LCP, and equally that they were sometimes reluctant to suggest that it may be appropriate in case this was seen as "giving up". There was a consensus that the department would benefit from further education regarding the use of the LCP.



Action

A Palliative Care Clinical Governance session was organised, with representatives from Palliative Care and Geriatrics speaking on the use of the LCP and end of life care.



Clinical Governance Palliative Care Session

For doctors, nurses and all involved in the provision of palliative care

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When to put someone on the LCP
Artificial nutrition and hydration at the end of life
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Wednesday 12 May 2010

The audit resulted in increased awareness of the LCP amongst staff in our unit. All staff received formal education on the use of the LCP, and it has provided a forum for discussion. A reaudit was conducted over a two month period. Uptake of the LCP had improved, and out of 14 patients entered into the audit, only 2 were not on the LCP. Goal assessment had also improved.

