Developing Documentation for End of Life Care.

Joy Farquharson, Quality & Governance Manager,
St Andrew's Hospice, Lanarkshire.

Introduction

Following the recommendations of the Neuberger Report[1] on the use of the Liverpool Care Pathway (LCP) and subsequent guidance from Scottish Government (SG)[2], as the only provider of specialised inpatient palliative care in Lanarkshire, we developed a means of recording, evidencing and auditing end of life care which met requirements of the SG's four principles:

- Informative, timely, sensitive communication
- Significant decisions about a person's care, including diagnosing dying, are made on the basis of multi-disciplinary discussion.
- Each individual person's physical, psychological, social and spiritual needs are recognised and addressed as far as is possible.
- Consideration is given to the wellbeing of relatives or carers attending the person.

Aim

To develop a robust means of evidencing appropriate end of life care which follow SG's 4 principles.

Methodology

Following extensive review of the Neuberger report and the Guidance of SG, 13 key objectives were agreed in relation to evidencing and auditing appropriate end of life care as follows:

1. Clear reasons for diagnosis of dying
2. Evidence of an agreed plan for managing patients care
3. Evidence of an agreed plan of care being reviewed and updated at least daily
4. Record commenced by a Senior Clinician
5. Name of the family to contact recorded
6. Evidence of 4 hourly review
7. Patient aware they are dying
8. Relatives aware patient is dying
9. Patient given the opportunity to discuss what is important to them
10. Relatives given the opportunity to discuss what is important to them
11. Clinically assisted Nutrition reviewed
    a. Nutritional Care Plan explained
12. Clinically assisted hydration reviewed
    a. Hydration Care Plan explained
13. Relatives can express understanding of next steps

These were developed into a Suite of Documents (Table 1) which compose an End of Life Care Record (EoLCR).

Table 1: EoLCR Suite of Documents

Document	Purpose
EoLCR Initial Assessment	To record diagnosis of dying and undertake a full assessment of the patients current condition and review medications, interventions, nutrition and hydration.
EoLCR Care Plan	To record an agreed Plan of Care for the patient based on the assessment carried out.
EoLCR Multi-disciplinary Notes	To record ongoing care provided and any changes in the Care Plan.
EoLCR Daily Ongoing Assessment of Care	To record ongoing assessment of the care required and delivered to patient at least every 4 hours. Any variances to be recorded and action taken. New document required daily.
EoLCR Reassessment	Following 72 hours using the EoLCR, the patient's status should be reviewed and any changes in the Care Plan documented and actioned.
EoLCR Care After Death	To record care provided to patient and family at the time of and following death.

The project comprised two stages:

Stage 1 (5 week pilot)

- Ward A: Patients identified as being in the last days/hours of life, care documented in EoLCR
- Ward B: Patients identified as being in the last days/hours of life, care documented in Personal Care Records (PCR).
- All data compared against the 13 objectives
- Minor amendments were made and the EoLCR rolled out to all wards

Stage 2 (Retrospective Audit)

- A retrospective audit was undertaken of all deaths within the hospice over 3 months of implementation and compared against the 13 objectives.

Results

Figure 1: Results from objective 1-6

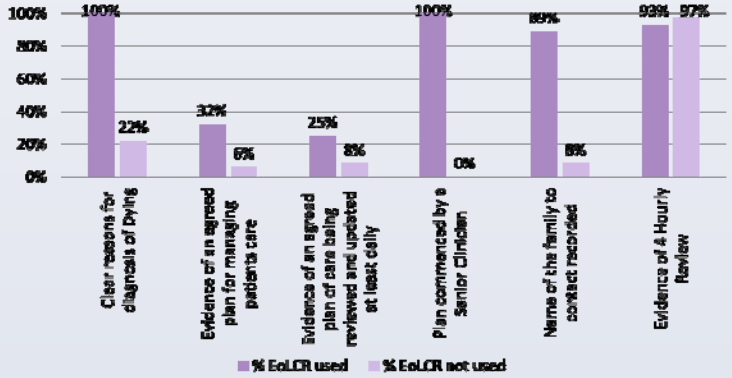
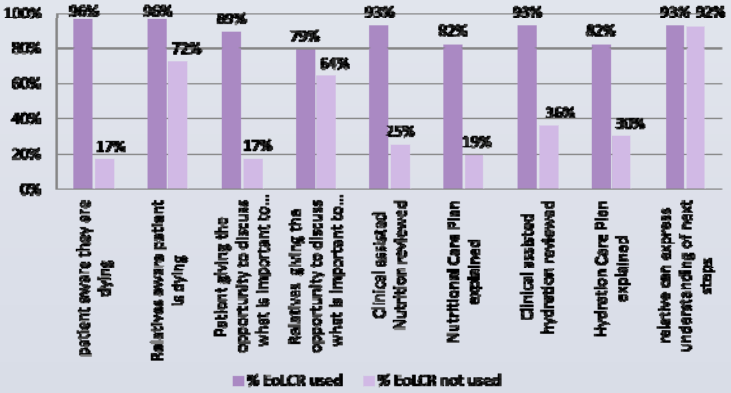


Figure 2: Results from objective 7-13



Conclusions

This project showed that the new EOoLCR Suite of Documents provide a more robust way of recording, monitoring and auditing end of life care than continuing to document care in patients PCR. This extensive audit of the use of the EoLCR within St Andrew's Hospice over a 3 month period has demonstrated that the use of the EoLCR allowed us to evidence that we are meeting the principles set out by the Scottish Government in relation to good end of life care. Non-use of the EoLCR doesn't mean good care does not take place, however it makes it more difficult to evidence.

References

1. Neuberger J. More care, less pathway: a review of the Liverpool care pathway. (2013)
2. Scottish Government. Caring for People in the last days and hours of life. (2014)

This work was undertaken in conjunction with the NHS Lanarkshire Palliative Care MCN

joy.farquharson@standrews.scot.nhs.uk