

Frailty and the impact of electronic advance care planning records on readmission rates and location of end of life care

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Introduction & Aim

Older people with severe frailty are 5 times more likely to die in the next 12 months than older non-frail people however prognosis and disease trajectory in frailty remains difficult to predict.¹ Advance care planning (ACP) is often not fully discussed or documented due to these prognostic uncertainties, alongside other time and workload constraints.² This can result in multiple admissions for people with frailty in the last 12 months of life and can lead to care and death in a non-preferred place. Electronic advance care plans (eACP) can be shared across hospital, GP, community and ambulance services. This can be useful in reducing unwanted admissions and promoting care and death in preferred location as well respecting other individualised needs and wishes, such as spiritual care needs.

This project aimed to improve proportion of patients receiving care in their preferred location and reduce readmission rates.

Method

Identified patients who wished to avoid hospital readmission with clinical frailty score of 6 or more and at least 2 unplanned admissions in the preceding 12 months over a 4 month period at a district general hospital in south London. ACP was discussed with capacitous patients and families, and an individualised eACP was completed. Previously, this cohort of patients would have had a non-electronic advance care planning document completed, called a PEACE plan.³ Patients were then followed up at 3 and 6 months to assess readmission rate and proportion receiving end of life care in their preferred location.

References

1. Clegg A, Bates C, Young J, Ryan R, Nichols L, Ann Teale E, et al. Development and validation of an electronic frailty index using routine primary care electronic health record data. *Age and ageing*. 2016;45(3):353-60.
2. Elliott M, Nicholson C. A qualitative study exploring use of the surprise question in the care of older people: perceptions of general practitioners and challenges for practice. *BMJ supportive & palliative care*. 2017;7(1):32-8.
3. Hayes N, Kalsi T, Steves C, et al Advance Care Planning (PEACE) for care home residents in an acute hospital setting: impact on ongoing advance care planning and readmissions *BMJ Supportive & Palliative Care* 2011;1:99.
4. Public Health England, End of life care profiles. Office for National Statistics, Rolling annual death registrations by place of occurrence, England.
5. National Survey of Bereaved People (VOICES): 2013. Office for National Statistics, England.

Conclusions

Targeted use of eACP resulted in:

- High proportion of people receiving end of life care in their preferred place
- Low readmission rate

High quality advance care planning discussions take time.

Workload & time constraints made it difficult to offer the opportunity of advance care planning discussion as widely as planned.

Results

24 patients consented - 17 women, 7 men. 1 patient declined to give consent for completion of an eACP following discussion. Mean age was 88.3 with mean pre-admission frailty score of 6.1. There was a high level of pre-admission co-morbidity with 80% having 3 or more major comorbidities.

Readmission rate was 8% compared with 25% for patients with a PEACE plan and 56% for patients without an ACP document.³ One third of patients were alive at 3 months, all without readmission. 23 patients had died by 6 months. 13% of patients died in hospital (1 patient deteriorated with ambulance crew and was brought back to their bedspace prior to leaving the hospital) versus a national average of 44% in 2021.⁴ 100% of patients/families expressed a wish for place of care and death to be in usual residence (either home or care home) with 70% of patients dying in their preferred place of death versus national average of 53%.⁵

The average length of ACP discussions was just over 30 minutes, excluding time building a relationship with patients and families over the course of an admission. It then took between 15-30 minutes to complete the eACP.

Discussion

Electronic ACPs improved the healthcare team's ability to provide care in the patient's preferred place. Although not a measured outcome, the reduction in readmission rates would likely have resulted in a financial saving for the trust and an overall lower financial cost of care in last months of life.

This project aimed to include all patients admitted who fit the inclusion criteria however good ACP discussion is time-consuming. Due to workload constraints, it was not feasible to discuss ACP with every patient. There was a degree of clinician selection to ensure that ACP was targeted for patients who were felt would benefit most and/or were felt to have shorter prognoses. This likely resulted in a higher 6-month mortality rate than otherwise may have been expected.

Although ACP discussions generally took around 30 minutes, this was done on a foundation of prior patient & family relationship building and updates often spanning multiple days or weeks of admission. This data is unlikely to be applicable to "cold" introduction of ACP in settings, such as Frailty units, with short admission times and less time to build rapport/trust. In these settings, ACP could be introduced with outpatient or community follow up for further discussion.

Figure 1. eACP vs National average

