Transforming Advance Care Planning (ACP) practice with the rollout of EPIC in post-acute geriatric medicine wards practice.

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Introduction

Advance care planning (ACP) allows patients to prepare for their future and articulate their care preferences. Despite it being a major policy focus there are significant barriers that effect ACP delivery, including paperwork burden and information sharing difficulties.

Electronic Health Records (EHRs) are fundamental to how ACP conversations are recorded and communicated. We present data from an inpatient geriatric medicine unit during a change in trust-wide EHR (namely, EPIC) and a contemporaneous ACP educational drive.

Aim of the Quality Improvement Project

To capture the practice of ACP over time, to help inform further interventions and EHR build changes.

- Ultimately to improve the quality and quantity of ACP within the geriatric team.

Timeline

Time point 1. Data collection
July '23

October '23 — EPIC role out

April '24 — Time point 2. Data collection

Methods

Clinical notes for all patients on three geriatric wards were analysed on a single day in July 2023 and April 2024. EPIC was rolled out in October 2023. Demographics including age, admission, discharge destination, clinical frailty score (CFS) and social circumstances were retrieved and notes were reviewed for ACP decisions.

Concurrent teaching took the form of regular small group seminars for ward teams, and departmental sessions to build confidence and optimise ACP documentation using the new software.

July 2023: Round 1 and baseline

Key results

n= 85
Demographics

Mean Age: 82

67% of patients CFS 6 or over

81 admitted from home
4 from a Nursing Home (NH)

DNACPR:
For Full Escalation: 22 patients
DNACPR: 63 patients

Peace plans in place: n=1

Universal Care Plan in place: n=0

Key findings and opportunities after round 1

Low rate of ACP practice.
- Cumbersome and variable upload/ download practice for documents.
- Many juniors 'uncertain' about ACP.
- Identified need for regular teaching for rotating junior doctors

Difficulty accessing Universal Care Plan, via convoluted log-in process
- Aims to reduce barriers to access in EPIC

Multiple opportunities noted in EPIC to build and embed practice.
- Use quality improvement projects to monitor practice and stimulate innovation.

April 2024: Round 2.

Expanded data search using EPIC 'search bar' + key words.

Key results

Results; n= 83

Demographics

Mean Age: 84
61% of patients CFS 6 or over.

78 admitted from home
5 from a NH

Time

In the 12 months leading to admission-
69% patients had been admitted to hospital one or more times.
53% had been admitted to hospital two times or more.
Mean admission length: 30 days

What

DNACPR:
For Full Escalation: 18 patients.
DNACPR: 65 patients.

TEP:
59 pts (71%) documented TEP decision

ACP beyond DNACPR and TEP:
20 pts (24%) documented ACP plan
11% ACP pre-admission only
13% ACP re-visited/ new
8 pts (10%) Universal Care Plan.

Where

TEPs
46% in 'TEP Navigator'.
53% 'in text'.

ACP
35% in Navigator.
5% in an 'ACP note'.
60% in 'in text'.

Who

NH residents; n= 5
5/5 had ACP documented pre-admission.
2/5 had UCP documented pre-admission.

Amber Care; n= 8
5/8 had ACP documented before/ during admission.

Who performs ACP (beyond TEP)? n=20
52%: Consultants
12%: Palliative Care Team
9% : GPs
9% : SHOs
9% : CNS
6% : SPRs
3% : ICU

Key findings and opportunities after round 2

Analysis

Similar populations, improved quantity of documented Advance Care Plans
- Particularly for patients supported with 'Amber Care' bundle and NH residents.
- Room for improvement for other groups- functional decline and frailty, memory impairments.

Highly variable documentation strategy.

ACP is highly consultant dependent.
- Limited engagement on wards from SPRs.

Plan

Circulation of 'tip sheet' for documentation clarifying best practice.
- Via email and posters.

Discussion as a faculty to harness IT opportunities
- Ward round and discharge 'proformas', to encourage practice.
- Increasing 'visibility' of ACP from dashboard.

Extend project into the community.
- Assess @home practice.
- Create best practice ACP lanyards, to reinforce changes.

Steering group committee discussion
- Consider further outcome measures for round 3 and harmonise with trust-wide strategy.

Conclusion

Significant improvements were noted in ACP delivery and documentation. Following the launch of EPIC alongside targeted teaching to staff members, the proportion of patients with an ACP increased by 23% and UCP by 10% over a 9-month period.

EPIC includes improved ability to search for relevant information and dedicated space to document ACP plans, both of which may have contributed to these results. Future work aims to expand this learning into GSTT community services and across other trusts, capitalising on the potential of improved EHR technology in the NHS.