

# IMPROVING ADVANCED CARE PLANNING IN SEVERE FRAILITY

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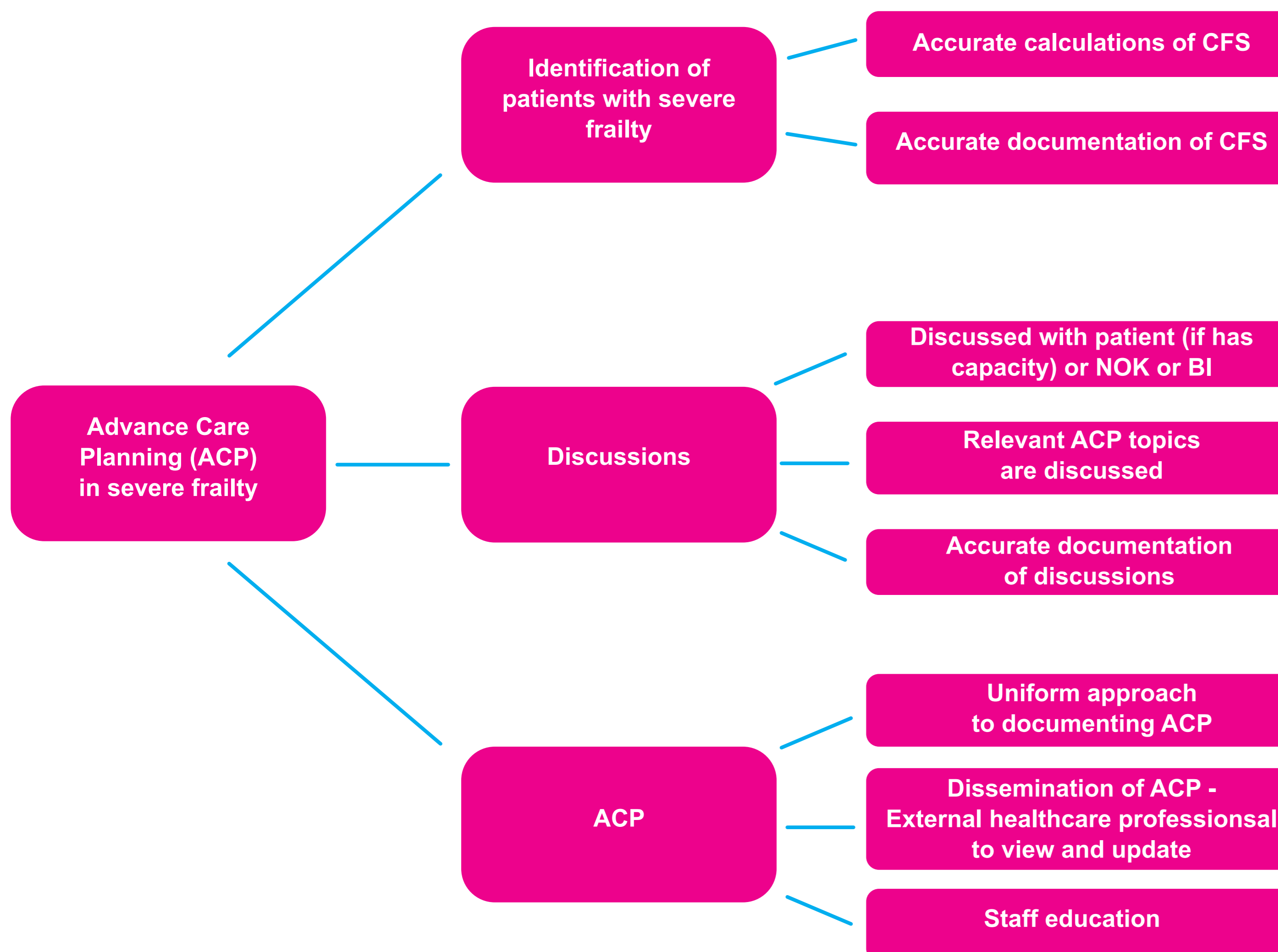
## Introduction

NICE guidance recommends that doctors need to identify patients who are approaching their final year of life<sup>1</sup>. It recommends using tools such as the Clinical frailty Score (CFS) to identify these cohorts. This was also reflected in the 'Getting it right first time' (GIRFT) document<sup>2</sup>, which recommends that all local health systems identify older people in the last phase of life and offer them Advanced Care Planning (ACP), so they can be looked after and die in their preferred place of care wherever possible. Wigan has a large population of frail patients who would benefit from ACP discussions<sup>3</sup>.

## Aims

The aim of the project was to establish a strategy for identifying patients with severe frailty who would benefit from ACP and establish a process for initiating conversation through appropriate transfer of care documentation. A successful outcome was defined as a minimum of 50% of all recorded cases, in patients identified with severe frailty (CFS ≥ 7), having an advanced care plan implemented or evaluated. The setting was an Ageing and complex medicine inpatient ward at The Royal Albert Edward Infirmary, over a 12-month period.

## Driver Diagram



## Method

Retrospective discharge letter data was used to identify patients aged >65 years and with a CFS of 7 and above, over the course of 5 distinct PDSA cycles during a 12-month period. Exclusion criteria included patients <65 years old, patients that died during admission, patients who moved wards prior to discharge and re-admissions if within 30 days. The cohort was examined to see if they had been recognised as a patient who would benefit from ACP, or if an aspect of ACP had been completed during their admission. In total, a cohort of 50 patients were selected.

**PDSA Cycle 1** – Education session about ACP, delivered to the departmental medical staff

**PDSA Cycle 2** – Optional box to record CFS added to the nursing admission documentation

**PDSA Cycle 3** – Local agreement between senior medical staff to record CFS during ward round (within 24-hours of admission to the ward)

**PDSA Cycle 4** – Introduction of the Electronic Palliative Care Co-ordinating System (EPaCCS), to standardise the documentation of ACP

**PDSA Cycle 5** – Introduction of ward posters and info cards to promote and encourage discussions around ACP

## Results

PDSA Cycle	Percentage of patients during PDSA cycle with an element of ACP identified or completed
Baseline	0%
1. Education	50%
2. Nurses Recording	46%
3. Recording CFS	0%
4. EPaCCS	50%
5. Frailty Cards	50%

Figure 1 - Results

The results (Figure 1) show that the cycles improved the number of patients having ACP discussions during the project. Most cycles were successful in reaching the 50% benchmark set at the start of the study. However, PDSA cycle 3 was particularly unsuccessful and overall, the improvements remain modest, whilst building upon or surpassing the target of 50% continues to be challenging.

## Discussion

Regrettably, the study highlights that we are still poor at recognising severe frailty and acting upon this. Furthermore, whilst implementing various changes can result in a spike in improvement, the longevity of these changes is not sustained (Figure 2).

Education around the topic of ACP was well received and appeared to have the biggest impact. Both medical and nursing staff were keen to incorporate ACP into their regular practice. However, it was felt that clinical commitments often superseded conversations around ACP, particularly in an inpatient setting.

Furthermore, it was noted that one or two individuals were felt to be 'champions' of ACP and their presence on the ward would often coincide with improved CFS documentation and subsequent ACP discussions. Unfortunately, during periods of their absence, the same vigour could not be replicated by the other members of staff.

Proposed recommendations to achieve a sustained improvement in ACP in a clinical setting include CFS documentation by the wider, allied healthcare disciplines (OT, Physiotherapy), as well as having a designated ACP professional responsible for supporting the discussions.

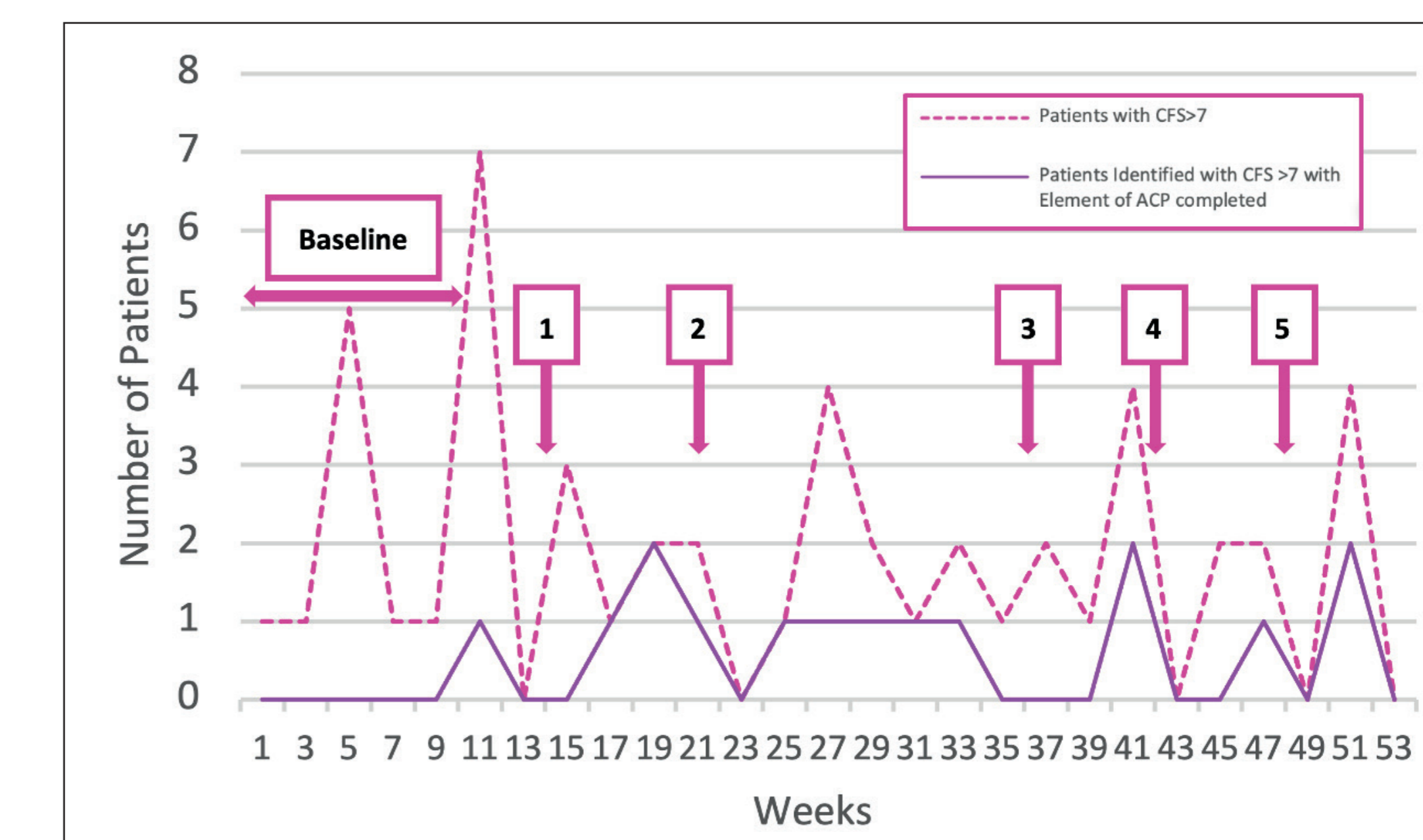


Figure 2 - Run chart for the 12 month period

## Conclusion

Severe frailty is an end-of-life state and should trigger a healthcare professional to identify and sensitively discuss end of life needs and preferences. Information on ACP should be disseminated to other health care professionals to allow them to act in accordance with the patient's wishes or best interest. Despite the best intentions of the medical team, implementing a sustained and successful approach to ACP remains challenging within an inpatient setting.

## References

- <https://www.nice.org.uk/guidance/ng142/chapter/Recommendations#identifying-adults-who-may-be-approaching-the-end-of-their-life-their-carers-and-other-people>
- <https://www.gettingitrightfirsttime.co.uk/medical-specialties/geriatric-medicine/>
- <https://www.wigan.gov.uk/Council/Data-Statistics/Borough-Story/Population-estimates.aspx>