

Improving Advanced Care Planning in Severe Frailty - Two Year Summary

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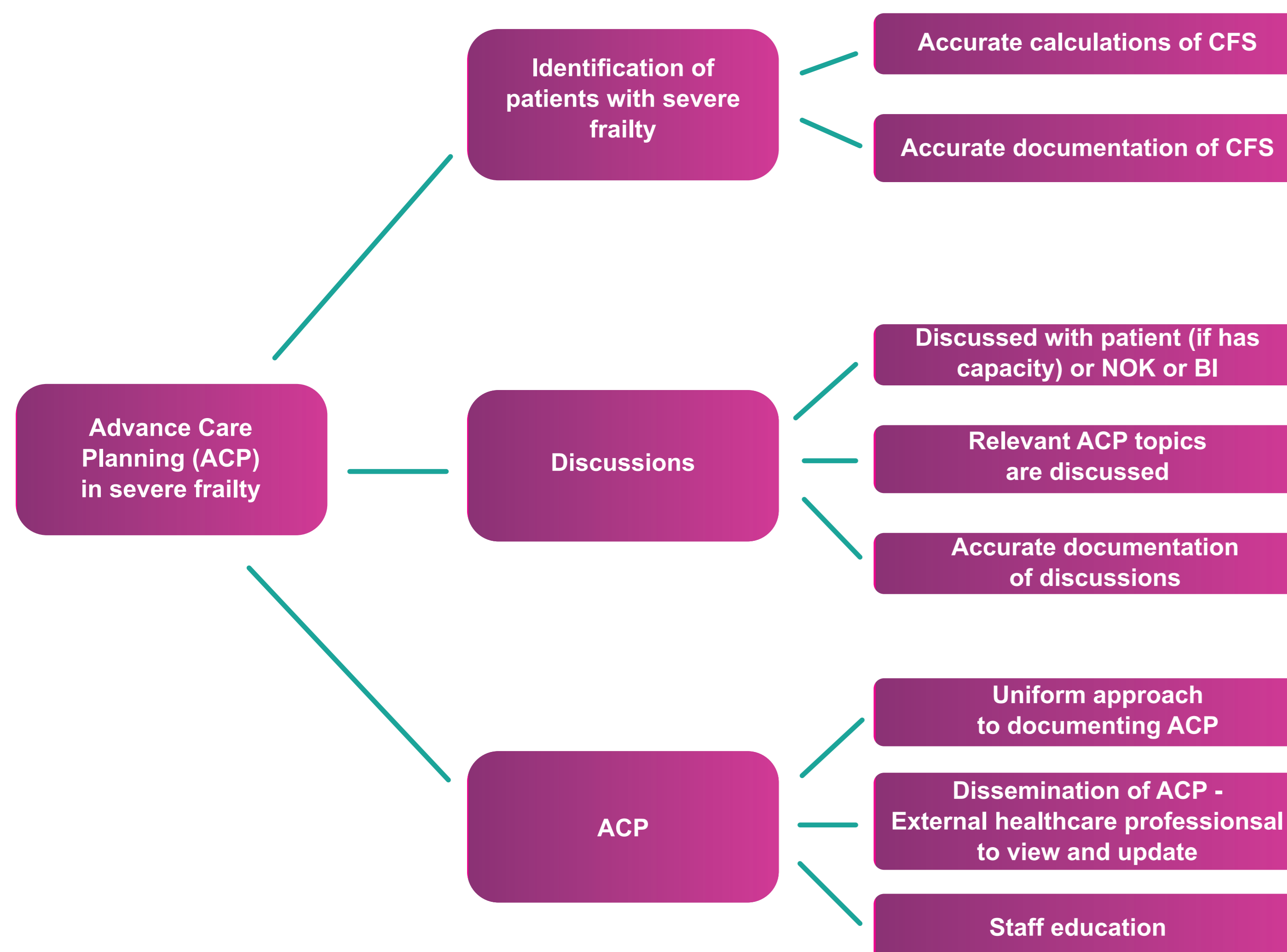
Introduction

NICE guidance recommends that doctors need to identify patients who are approaching their final year of life¹. 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) document², 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 discussions³. This 24-month project has involved two sets of 5 PDSA cycles. This poster focuses on the second 12 months and PDSA cycles 6-10.

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

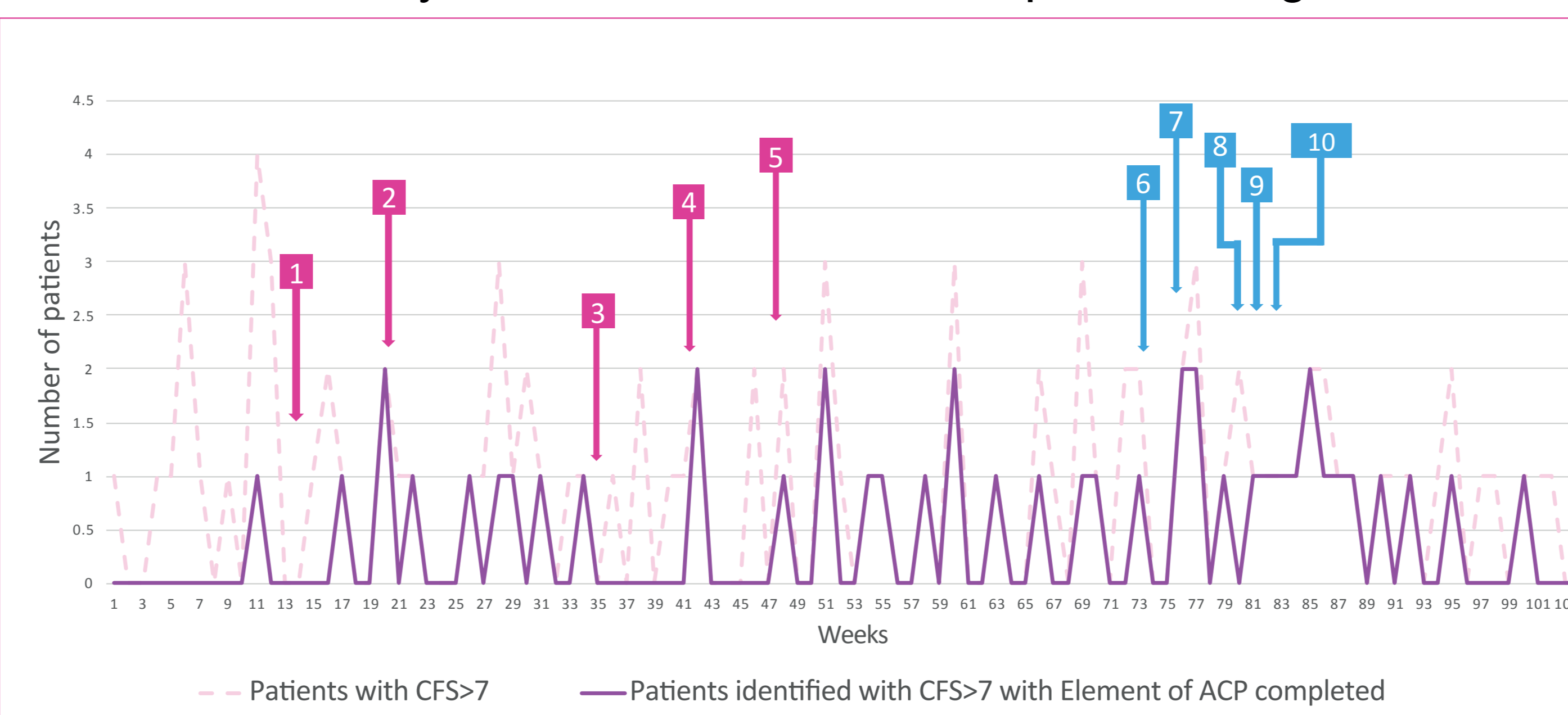
Retrospective discharge letter data was used to identify patients aged >65 years and with a CFS of 7 and above, over the course of 10 distinct PDSA cycles during a 24-month period. Exclusion criteria included patients who moved wards prior to discharge and re-admissions if within 30 days. The cohort 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. (PDSA cycles 1-5 conducted in year 1 with results published separately). Detail of all PDSA cycles undertaken are listed in Results section.

Results

PDSA Cycle	Percentage of patients during PDSA cycle with an element of ACP identified or completed <small>(* combined impact from start of cycle 8 to 5 weeks after cycle 10)</small>
Baseline	0%
1. Education	50%
2. Nurses Recording	46%
3. Recording CFS	0%
4. EPaCCS	50%
5. Frailty Cards	50%
Year 2 Baseline	56%
6. Medical team education	50%
7. ACM WR note documentation	83%
8. Dedicated ACP session	90%
9. Senior nurses ACP training	90%
10. Therapy Assessment for CFS	90%

The results (Figure 1) demonstrate that the interventions improved the number of patients having ACP discussions. All cycles reached the target of 50% and most far surpassed this aim. Data also showed that during the 20 weeks following the initial 12-month project, 56% (9/16) of severely frail patients identified, had ACP decisions documented. This was despite no interventions being introduced in this period.

Summary Two Year Run Chart Sept 2021-Aug 2023



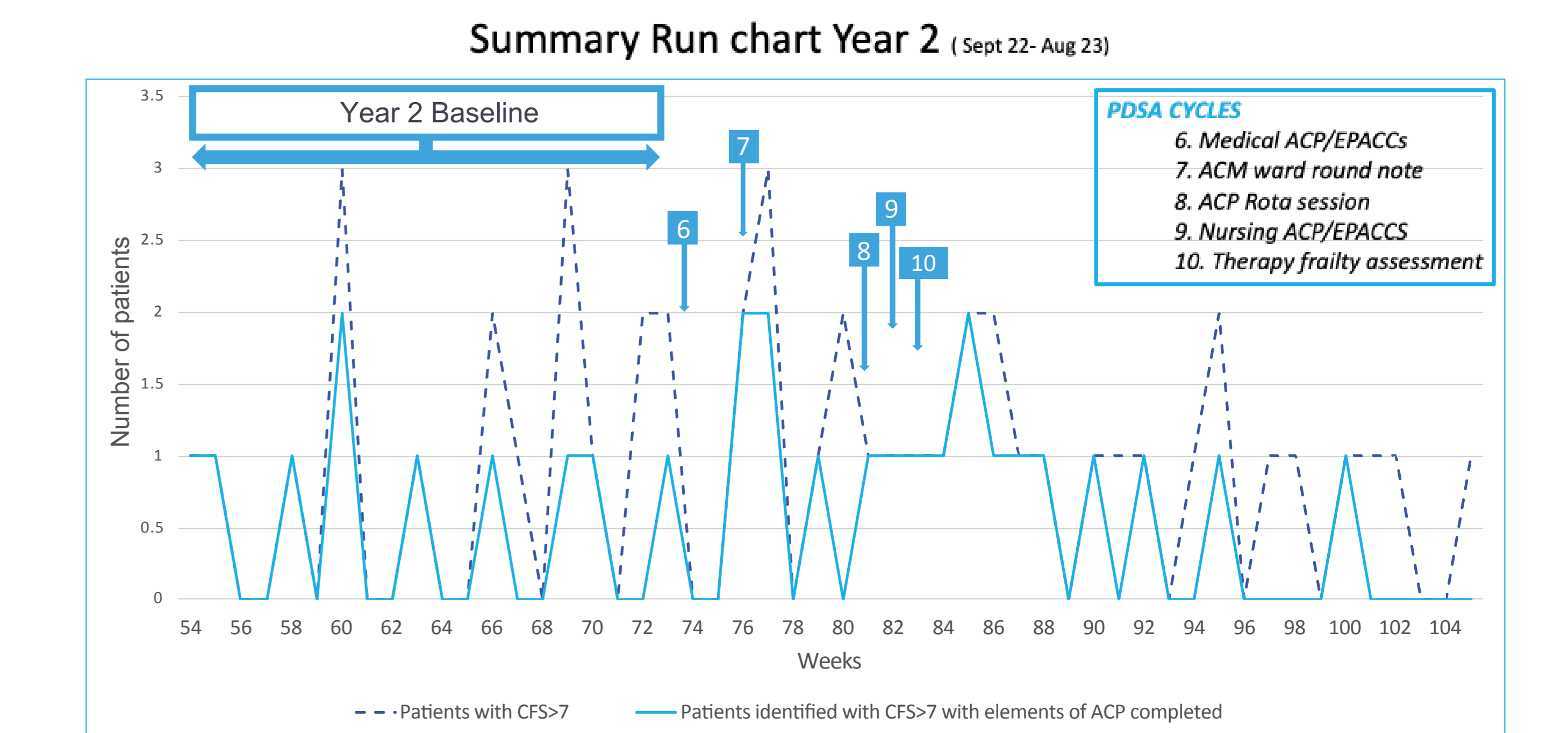
Discussion

Our data showed that the work conducted in the first 12 months had a lasting impact on quantity of ACP discussions taking place on the ward, as highlighted by the year 2 baseline data.

As with the first 12 months of the project, the data from the second year showed that although interventions continued to be effective at improving ACP uptake temporarily, there is great fluctuation.

Cycles 6, 9 and 10 were implemented in collaboration with external departments meaning their introduction point could not be controlled. This meant that cycles 8,9 and 10 were introduced on consecutive weeks thus their individual impacts could not be assessed. Therefore, we hoped that the condensed nature of these PDSA cycles, would lead to a high intensity strategy that would heighten awareness of ACP on the ward, with the aim of leaving a lasting influence. As is evident from the period following week 81, this successive implementation did lead to sustained improvement up to 90% (9/10). However, after week 89, the pattern of fluctuation returns and compliance diminishes.

Our recommendations for the future cycles involve continuing the ACP 'champion' approach by maintaining protected rota time for ACP and creating a specialized ACP note on our electronic record system that would auto populate onto the discharge summary.



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. The combined impact of all 10 PDSA cycles, over the 12 month period, has greatly improved the quantity of ACP discussions from our original baseline of 0%. Although many of our interventions have been temporarily effective, finding an intervention that sustains improvement remains the primary aim of this project.

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>