

# Supportive and palliative care research and audit conference

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## Oral and poster abstract submission template

Abstracts should be submitted to [samantha.wilkinson@srft.nhs.uk](mailto:samantha.wilkinson@srft.nhs.uk) by 5pm on Friday 30 September 2016.

**Title:** Auditing End of Life Care across the North West Region

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### Abstract

**Background:** The transition from the Liverpool Care Pathway to the Five Priorities for End of Life Care by the Leadership Alliance has marked a pivotal point in Palliative Medicine. This audit aimed to assess care in the last days of life across multiple settings within the region to evaluate standards and identify areas for improvement.

**Methods:** We used the five priorities of care to develop 45 standards and a 100-question proforma covering the duties and responsibilities of health care professionals. Each centre across the Strategic Clinical Network were asked to identify 15-20 expected patient's deaths occurring April-May 2015. Retrospective audit analysis from the patient's collective notes was carried out by medical staff (nurse or doctor) at each centre and electronically recorded. Analysis was carried out by the NWAG audit group, and individual and collated results distributed to each centre.

**Results:** 201 patients (median age 77 years) were included in the audit across 5 community, 10 hospice, and 1 hospital team(s).

Recognition of dying (91%) was documented more than assessment of reversible causes (74.6%). Physical needs were assessed (94.5%) more than emotional (67.2%) and spiritual (69.2%) ones.

Adequate review of medications varied greatly across sectors (0-97.5%), as did provision of mouth care (26.7-85.2%); and support for those close to the patient (6.7-81.9%).

Universally weak areas were daily review by a senior clinician (42%; range 18-60%); consideration of parenteral hydration (30.3%; range 12.5-46.7%) and nutrition (16.4%; range 9.4-33.3%); and documentation of advanced care planning discussions (28.9%).

Communication that the patient may die soon and the goals of care were more likely to occur with those close to the patient (68.2-90.2%), than the patient themselves (54.5%-79.6%). Communication regarding likely symptoms and side effects were more frequent with the patient (47.2-50%) than those close to them (29.9-38.8%). In most areas communication and its documentation showed significant need for improvement.

**Implications:** Site specific results have allowed targeting of deficiencies in individual centres. The audit highlighted the importance for clear documentation, especially where 'negative' findings exist (e.g. no pain), or in cases where discussions are perceived as inappropriate, e.g. patient confusion or distress. Identifying individual patient trigger points in care plans may help recognise patient's requiring senior review for difficult symptoms or unanticipated change.