Health Innovation Network South London

Barking, Havering and Redbridge University Hospitals NHS Trust

NHS

Success factors in improving use and quality of advance care plans across an Acute Trust during a pandemic

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Background

BHRUT is an Acute Trust encompassing two East London hospitals that serve a diverse community of approximately 750,000. The aim of implementing Coordinate My Care (CMC), which is the pan-London shared digital urgent and advanced care plan, in the Emergency Departments (ED) is to promote patient-centred care for those patients predicted to be in their last year of life. Despite this project being introduced during the pandemic and BHRUT having been one of the most heavily impacted trusts, the Specialist Palliative Care Team (SPCT) has continued working to improve usage of CMC.

Introduction

Prior to this project, ED staff were often unaware of Advance Care Planning (ACP) documents, which could be difficult to access. This issue was highlighted during the pandemic as hundreds of patients were admitted to hospital alone and too unwell to communicate their wishes. This led to concerns that patients may be admitted to hospital against their previously stated wishes, due to health professionals who would not be aware of their preferences providing crisis treatment.

An audit of ACP at the pandemic's onset compared CMC records to the paper documents previously in use, revealing challenges with cross-boundary accessibility to paper documentation and potential for error with hand-written documents. Evidence from the audit was presented to the BHRUT End of Life Care Advisory Committee, which concluded that CMC should now replace paper documentation in line with the rest of the locality and wider London area.

The goal was to accelerate the implementation of CMC, which has now been extended to the rest of the Trust, including the Paediatric departments. Initial focus was on the Care of the Elderly, with an emphasis on the quality of the Emergency Treatment Plan (ETP).

Method

Stakeholders who would be using CMC were identified from the local health economy and included the London Ambulance Service, Marie Curie, GPs, Community End of Life Care (EOLC) Facilitators, Hospice staff, Care Home managers and Patient Partners. We sought agreement from these stakeholders that CMC should be adopted by BHRUT as the only ACP documentation, as well as their support in the production of Standard Operating Procedure (SOP) and ETP guidance.

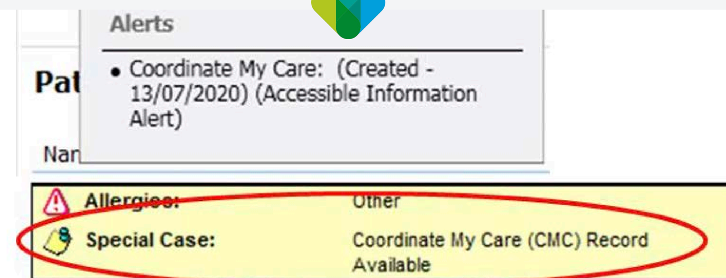
Stakeholder engagement clarified that the ETP should focus on advice for healthcare professionals with clear ceilings of treatment, that preferences relating to personal and social aspects of care should be included elsewhere in the CMC record and that a supplementary written information leaflet should be developed.

The following organisational subgroups were developed to guide quality improvement work:

- Acute Hospital
- Paediatrics
- Specialist Palliative Care
- Emergency Department

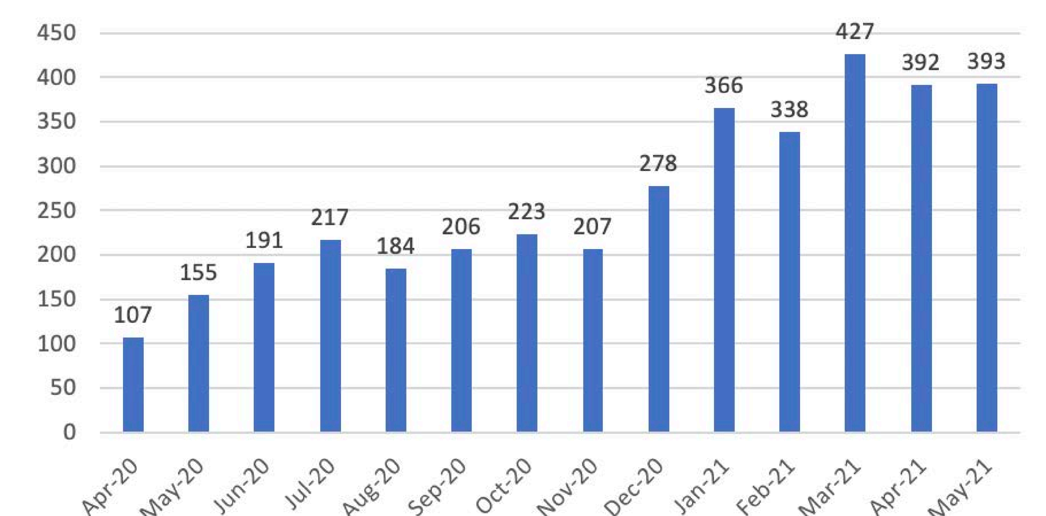
A CMC Facilitator was recruited and focused on the EDs initially, then to lead the rollout of teaching across the Trust. Roles and responsibilities for the use of CMC were clearly set out in the SOP.

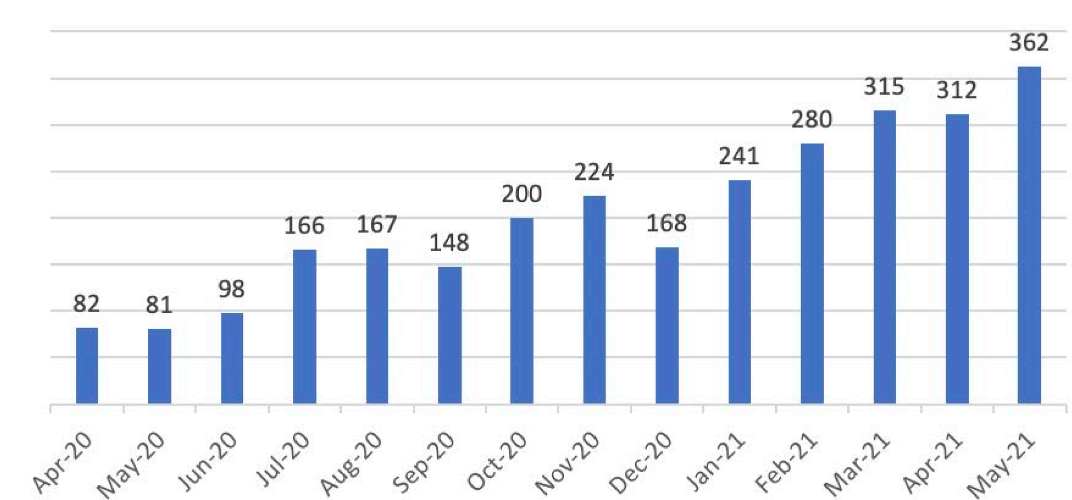
Alerts were manually created on the Trust IT system. ED reception staff then responded to these alerts by printing the record and highlighting it to clinical colleagues.



The impact is assessed using key performance indicators:

- Daily logins to CMC system by BHRUT staff.
- Number of CMC care plans published and revised at BHRUT.
- Non-urgent care views of CMC records created at BHRUT.





Results

Key performance indicators (KPIs) revealed an increase in activity (*see graphs to the right*).

The quality of ACP records recorded on CMC was audited for patients expected to be in the last year of life. The expectation is that anyone who is in their last weeks/short months of life should have an Emergency Treatment Plan recorded within their CMC.

This demonstrated **96% completion** of Emergency Treatment Plans and highlighted themes for further improvement. This audit will be repeated in six months following implementation of guidance for completion of emergency care planning.

The audit of Emergency Treatment Plans was based on completion of mandatory fields.

STANDARD	% COMPLIANCE
Preferred Place of Care	100%
Preferred Place of Death (first choice)	85%
CPR patient discussion	100%
CPR family discussion	85%
Clinical recommendation	96%
Crisis management	74%
Breathlessness	84%
Nausea and Vomiting	74%
Pain	84%
Terminal restlessness	70%
Worsening mobility and falls	67%
Worsening oral intake of food and fluids	67%
CMC records created that included an ETP	85%
Patients with a prognosis of days or weeks whose record included an ETP	96%

"I was alerted (via my subscription) that my patient was in ED. I went down to see her and found that she was dying. I knew that she did not want to die in hospital I could organise for her care in the community and facilitate her discharge. She died comfortably the next day."

Specialist Haematology Nurse

Challenges

- **Lack of interoperabiliy between internal and external IT systems**
- **CMC unavailable for patients who live outside of London**

Conclusions

To embed CMC sustainably, it is necessary to:

- dedicate a facilitator to leading on the implementation of CMC;
- continue to use EOLC and CMC facilitators to train staff in the use of CMC;
- monitor logins;
- cleanse data to ensure accuracy;
- audit CMC records regularly to ensure high quality;
- enlist departmental CMC Champions;
- seek solution for systems interoperability (i.e., in-context link); and
- ensure there is a stringent alternative process for patients who live outside Essex.

Useful tips

Stakeholder collaboration in decision-making and discerning the change objectives was essential to the project's success. Creation of the SOP for CMC use at the Trust was vital to the safe and successful planning and implementation of CMC. It is envisaged that the ETP guidance ensures CMC records are meaningful to professionals in a crisis and has, together with the SOP, provided a standard for us to audit against.

The cleansing of data by establishing organisational subgroups and streamlining of job titles was essential to ensure CMC data was meaningful and reliable to measure the impact of quality improvement.

Next steps

Quality improvement training will be established across other specialties in the Trust. Focus will also continue on embedding a high-quality standard of record creation.

To ensure the use of CMC is embedded into best practice, the SPCT will continue to provide education and support to the generic workforce. A range of educational methods are used to ensure all types of learners' needs are met. YouTube videos and a podcast discussing the benefits of CMC for patients have been developed to ensure the information is disseminated.

The podcast is available at: https://clairebatestinkler.podbean.com/e/advance-care-planning-and-cmc/.