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Editorial comment: A future care planning initiative to improve the end of life care of patients on the complex care ward of a district general hospital

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OVERVIEW

Editorial comment on 'A future care planning initiative to improve the end of life care of patients on the complex care ward of a district general hospital' by Debbie Benson

A patient admitted to a geriatric or complex care ward often has multiple long-term conditions, is frail and has cognitive impairment. Many of these patients are nearing the end of their lives particularly those who are discharged to a nursing home. Those who work on geriatric wards will readily recognise this group, for whom good care planning would avoid unnecessary interventions and unnecessary hospital readmissions. In particular, admissions in the terminal phase, when the patient or their carers wish for a death outside of the hospital, should be avoided.

In this issue, Benson presents an initiative for future care planning in such patients.[1] Importantly, this project was medically led and was linked to community palliative care services. The study used the modified Proactive Elderly person's Advisory CarE (PEACE) process. Encouragingly, all eligible patients (or their carers) agreed to participate. Over a six-month period, 42 patients were discharged with a PEACE plan. Most patients lacked mental capacity to make end of life decisions. Use of the plan resulted in no inappropriate readmissions and none of the 45% of patients who died did so in hospital. This useful paper shows that for this group of patients, a structured approach to end of life care planning is possible and can result in successful outcomes.

The evidence suggests that end of life care planning could be done better on geriatric wards. In England about 53% of all deaths occur in hospital despite most people wishing to die at home.[2] One review found that 44% of hospital deaths occur in people who could have been recognised as being in the last year of life and that 20–33% could have been cared for outside of hospital if the right end-of-life care services were in place.[3] We know that many patients admitted to a care home are near the end of their lives, indeed only 55% survive for more than one year.[4] We also know that hospital re-admissions due to end-of-life issues are common, and accounted for 15% of readmissions in one study in Boston, USA.[5]

Why are patients near the end-of-life being admitted to hospital and indeed dying in hospital when it is not their wish? The problems may be lack of recognition that they are dying, lack of planning and lack of communication. Simple indicators, such as the surprise question used in the Gold Standard Framework ('would you be surprised if this patient were to die in the next few months, weeks, days?'), can be helpful to identify such patients for further care planning. Use of Gold Standard Framework in care homes has been found to increase the number of individuals with advanced care plans in place and those dying in the home, and reduce crisis admissions to hospital.[6] Another useful approach is the Amber Care Bundle based on 'rainy day planning' so that one has a plan for a poor outcome when it is uncertain what to expect.[7]

Health professionals have always been involved in planning for end-of-life care and some may argue that the above approaches are merely basic good medical practice. However, a structured checklist may avoid omissions to which even the most experienced practitioners can be susceptible.[8] Following the controversy around the Liverpool Care Pathway the need for an individualised approach has been highlighted. The public inquiry into the Mid Staffordshire NHS Trust also called for better teamwork and interaction between staff, patients and carers. The PEACE model satisfies all of these requirements. In the Future Hospital this type of approach will significantly improve the experience of end-of-life care for these patients and their carers. ■

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