Emergency healthcare planning within County Durham and Darlington NHS Foundation Trust: a case study of innovative practice

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ABSTRACT

The number of people in the UK living with significant, life-limiting health problems and severe disabilities is rising. As a result, robust proactive care planning and good communication of care plans across care boundaries are an increasing priority. Emergency healthcare plans are proactive care plans that are designed to communicate management plans for predictable health events and to facilitate communication and documentation of individualised treatment plans. This was evaluated within our trust through the surveying of attitudes in primary and secondary care, identifying support before implementation of emergency healthcare plans and subsequent review of outcomes. We implemented 25 plans in patients with advanced dementia, metastatic cancer, and end organ failure. All died in their preferred place of care, with most dying in the community. At 30 days after discharge, no patients had been readmitted to secondary care; at 90 days one patient had been readmitted. There seems to be substantial support for emergency healthcare plans among healthcare staff. These plans have potential to improve care for patients approaching the end of life, by supporting patients to be treated in their preferred place of care, reducing unnecessary admissions and improving communication.

KEYWORDS: Anticipatory care planning, emergency healthcare planning, preferred place of care

Introduction

The UK has a growing elderly population. By 2030, one in five people in England will be older than 65 years.[1] Additionally, the number of people in the UK living with severe health problems, life-limiting illness and significant disability is increasing. This issue is magnified within the demographics of inpatient populations, with patients older than 85 years accounting for around 22% of all hospital bed days.[2] Around 25% of hospital inpatients have a diagnosis of dementia.[3] These patients often have predictable fluctuations in health. During a health crisis, clinicians might be tempted to offer treatment or admission to hospital that might not be beneficial to the individual's long-term prognosis but can result in patients not being cared for in their preferred place at the end of life.

County Durham and Darlington NHS Foundation Trust takes acute medical admissions across two sites, the University Hospital of North Durham and Darlington Memorial Hospital. The trust also encompasses several community hospitals. It is one of the largest integrated care providers in England, and serves roughly 600,000 people. There is interest within the local healthcare system in improving integration of care across boundaries. Within the elderly care department, most patients have a high level of physical dependency and clinically significant comorbidities. Robust, proactive care planning and good communication of these plans across care boundaries could help to improve the quality of care received by patients. Although methods of advanced care planning have been used in similar populations, evidence is scarce.[4] The importance of care planning is recognised by many organisations, including the RCP.[5] It is also a key part of the Gold Standards Framework.[6]

Solution and methods

Emergency healthcare planning is a method of proactive care planning, the aim of which is to improve communication of plans across healthcare boundaries. Emergency healthcare plans are designed to enable the use of shared decision making to communicate management plans for predictable health events and to facilitate communication and documentation of individualised treatment plans. Content can vary greatly depending on the patient's anticipated emergencies, preferences and priorities, and they are designed principally for patients with complex healthcare needs who might be approaching the end of life. Emergency healthcare plans are contained within the Deciding Right Framework.[7]

We embarked on a clinical effectiveness project – to initiate and review the use of emergency healthcare plans in our trust

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by looking at markers such as mortality, effect on readmissions and preferred place of end-of-life care. Before introducing emergency healthcare plans, we surveyed local healthcare workers (both in community and hospital settings) about the plans as part of preliminary work to maximise effectiveness while minimising any perceived risks. The questionnaires consisted of a modified Likert scale, gauging opinion on how emergency healthcare plans could improve patient care, affect staff workload, improve communication and have a role in reducing emergency admissions. Overall, we distributed 150 questionnaires in person and via email across hospital sites and at several integrated meetings, including a local Deciding Right launch.

Emergency healthcare planning was introduced for specific inpatients selected via multidisciplinary assessment that depended on the patient having an advanced disease process with anticipated emergencies that could potentially benefit from the plan, and the patient's wishes to have one. Thus, the sample does not represent all inpatients who could have benefited from emergency healthcare plans. Completion of the plans was led by consultants and was included in current job plans.

When patients were discharged with an emergency healthcare plan in place, the plan was communicated to primary care in the discharge letter. Feedback was sought from the relevant primary care practice via email. At 90 days after discharge, mortality data, readmission data, and data for preferred location of end-of-life care were reviewed for patients with emergency healthcare plans in place.

Outcome

We received 120 completed surveys from healthcare professionals in primary and secondary care – 48 doctors, 57 nurses, 5 allied health professionals and 10 unknown. 90% of respondents agreed that emergency healthcare plans would improve patient care (112/120), 86% thought that these plans would improve communication between professionals (103/120) and 87% (104/120) thought they would improve communication with patients and families.

We implemented and subsequently reviewed 25 emergency healthcare plans between March 2014 and January 2015. Six were implemented in gastroenterology and 19 in elderly care within Darlington Memorial Hospital. The mean age of the inpatients for whom the plans were initiated was 84.4 years, and the predominant advanced pathologies were dementia (72%; 18/25), metastatic cancer (28%; 7/25) and end organ failure (12%; 3/25) with some patients having coexisting pathologies. The patients chosen had many previous emergency hospital admissions, and 14 had had an unplanned admission within the 90 days before the admission during which their emergency healthcare plan was initiated.

We discussed the emergency healthcare plan with all patients (or their next of kin if the patient did not have the mental capacity). All patients were discharged to their preferred place for end-of-life care (Table 1), with three choosing to receive end-of-life care in hospital. Community patient mortality was 28.6% (6/21) 7 days after discharge and 76.2% (16/21) 90 days after discharge. The three patients who chose to receive care in hospital were also dead at 90 days (Fig 1). All patients so far have died in their preferred place of care. Within 30 days of discharge, no patients had been readmitted to hospital, and at 90 days' follow-up there had been only one readmission to secondary care.

The emergency healthcare plan was identified on the discharge letter of 90% (19/21) of patients discharged to the community. We emailed the GP surgeries for the 22 patients discharged to the community for feedback and received nine replies, with limited feedback comments (Box 1) – too few to draw meaningful conclusions, but also no complaints.

Table 1. Place of discharge.

Place of discharge	N
Own home	4
Care home	17
Hospice	1
Hospital (as preferred place of care)	3

Conclusion and next steps

Generally across primary and secondary care, there seems to be an appreciation that anticipatory care planning is warranted in the context of advanced end-stage-disease processes. Although our quality-improvement and clinical-effectiveness project

Key points

There seems to be substantial support for emergency healthcare plans from healthcare workers from different healthcare settings.

Emergency healthcare plans show substantial promise in terms of maximising the numbers of patients cared for in their preferred place of care.

They could also reduce unnecessary hospital admissions while enhancing quality of care.

Improved communication and documentation of complex plans is an important aspect of care across healthcare settings that emergency healthcare plans could potentially help with. ■

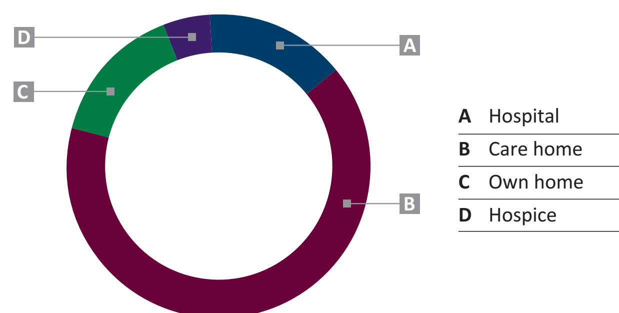

Fig 1. Place of death for patients with emergency healthcare plans.

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Box 1. General practitioners. comments

'The EHCP done was very helpful in this patient's end-of-life care. The main concern with this patient was her poor oral intake. The EHCP provided clear and concise information and recommendations for treatment regarding this.'

'This patient had a comprehensive care plan developed via the unplanned admissions system and the EHCP provided valuable information to the plan.'

'We do not have a copy of the EHCP so have no knowledge of what is planned. In addition, in primary care we have our own care plans.'

included only a few patients and had no comparison groups (ie, we have no data for outcomes in similar patients who did not have emergency healthcare plans), some encouraging themes seem to be developing.

Emergency healthcare plans show promise in enhancing communication between healthcare professionals and patients (or their next of kin). They take into account preferred place of end-of-life care and encouragingly seem to effectively support patients to get their wishes. Research suggests that hospitals are not often patients' preferred choice for end-of-life care but most deaths still occur in them, and thus the substantial proportion of participants who died in the community compares favourably with the 43.7% quoted in public health statistics.[8] This achievement resulted from individualised and considered care plans. As a result, inappropriate readmissions to hospital with anticipated emergencies were low and feedback has been generally positive, although clearly limited. Further, large-scale studies are warranted.

Emergency healthcare plans have the potential to improve communication of complex plans between primary and secondary care, but our data are limited because of the paucity of responses from primary care. Further studies would benefit from being done in close collaboration with colleagues from primary care and community services. Work to assess patient and carer perspectives on emergency healthcare plans, which we did not include in our review, might help to direct their use further. ■

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