A quality improvement project to improve the documentation of resuscitation and ceiling of care decisions in elderly patients at a large district general hospital

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Aims

All elderly patients seen on post-take ward rounds should be assessed by the Gold Standards Framework (GSF), with resuscitation status and ceiling of care discussed and documented accordingly in the medical notes and discharge letters.

Methods

We opportunistically reviewed the medical notes and discharge letters of all patients aged over 75 years immediately prior to discharge. We conducted three cycles of data collection, each lasting 1 week in duration, from November 2017 to January 2018. Data was recorded into an anonymised Excel template. We determined a pre-intervention baseline in cycle one, with a view to compare the trend after implementing two interventions separately in the next cycles. In cycle two, we delivered a presentation at the quarterly geriatrics meeting. In cycle three, we emailed recommendations to all doctors based at the trust. We determined the outcome of each intervention.

Results

In the pre-intervention sample (n=35), only 51% patients had GSF documented. In cycle two (n=45) this was 49% and in cycle three (n=22) this fell to 32%. In cycle one, 65% (13/20) of patients deemed 'not for resuscitation' (NFR) had no documented escalation status in the notes. In cycle two this was 46% (12/26) of NFR patients, and in cycle three this fell further to 14% (1/7). NFR status in cycle one was not communicated in 70% (14/20) of patients' discharge letters. In cycle two this fell to 35% (9/26) and rose to 100% (7/7) in cycle three. Seven patients met the GSF criteria in cycle one, 13 patients in cycle two, and four patients in cycle three. Regarding GSF patients in cycle one, 28% had no documented resuscitation discussion and 57% had no documented ceiling of care. In cycle two all GSF patients had a documented resuscitation discussion and only 25% had no documented ceiling of care. In cycle three, 75% had no resuscitation discussion documented and 25% had no documented ceiling of care.

Conclusion

The study demonstrates an overall improvement in documentation, particularly with the second cycle intervention. However, there is a relapse in standards in cycle three. This implies that the direct delivery of teaching sessions is far more effective than blanket emails. It also suggests that interventions need repeated administration to achieve the desired adequacy in documentation. The subpar documentation in cycle three may reflect the increased winter pressures at this point in the study and may also be confounded by the low discharge rates reducing sample size. ■

Conflict of interest statement

The authors collectively note reviewing a very small number of patients whose documentation had been completed by themselves, but the effect was not considered large enough to influence the results.

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