Emergency Healthcare Planning by a Community Geriatric Service

Dr H Filler, Dr J Dunbar, Dr M Rudd, Dr D Mayne & Dr M Bateman

Department of Geriatric Medicine, Sunderland Royal Hospital

Introduction

- A survey of those approaching the end of life suggested less than 1% of people would chose hospital as their preferred place of death [1]
- In England in 2013 48% of deaths occurred in hospital [1]
- Tevendale described implementation of EHCPs in 25 elderly inpatients and demonstrated achievement of preferred place of death and low rates of readmission [2]
- The community geriatrics team (CGT) identify patients' preferred place of care, and where appropriate help to formulate emergency health care plans (EHCP)
- An EHCP is a means of communicating agreed responses to anticipated emergencies and reflect the wishes of the individual [3]

Objectives

- To determine the proportion of patients with an EHCP or preferred place of care (PPC) who remained out of hospital within the circumstances described
- To define reasons patients were admitted
- To determine if admissions were in accordance with EHCPs and therefore clinically appropriate
- To define the proportion of patients who died in their PPC
- To describe the number of inpatient bed days used before and after EHCP / PPC

Methods

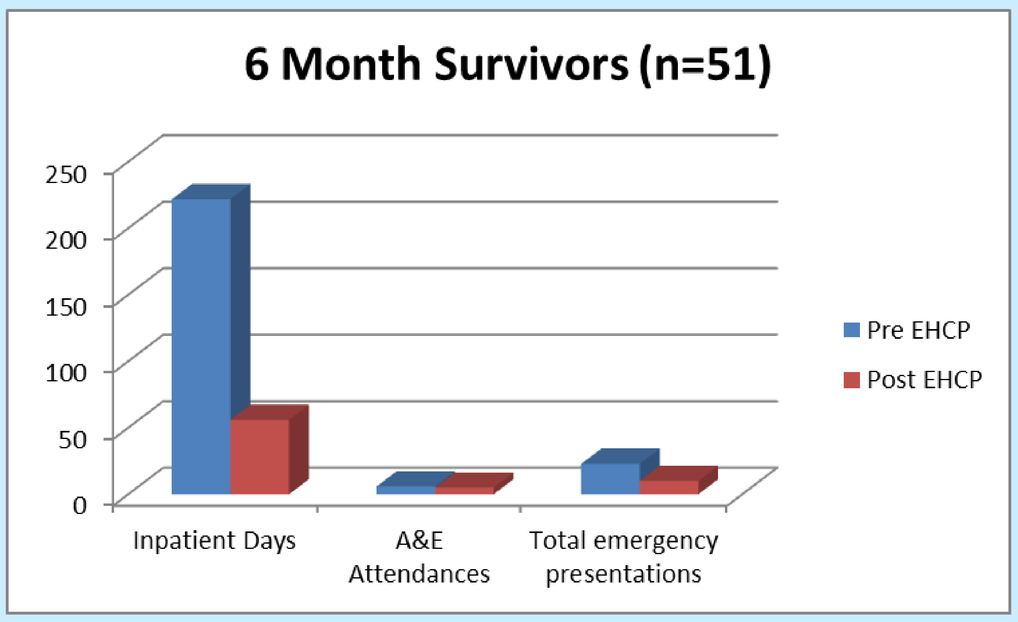
- CGT workload spread sheets were screened from service inception, to 6 months prior to data collection (01/04/2014 to 30/07/2015)
- Retrospective data was collected from electronic and paper medical records, CGT notes and EHCPs
- Data included demographics, date of EHCP/PPC, admissions 6 months before and after, admission diagnoses, place and date of death
- Analysis was cross checked by the data collection team to ensure consensus
- 138 patients were included in the final analysis.

Results

- 138 patients
- 38 male, 100 female
- Median age 86 years (Range 54 – 102)
- 84% patients were not admitted to hospital post EHCP
- 22% of patients admitted pre EHCP/PPC were also admitted afterwards. 7% of patients who were not admitted pre EHCP/PPC were admitted afterwards.

N = 138	6 months pre EHCP/PPC	6 months post EHCP/PPC
Patients admitted	83	22
Inpatient total LOS (days)	1808	167
Median LOS (days)	17	2
Patients attending A&E	38	9
Total A&E attendances	64	14
Patients with an emergency attendance	93	26
Total number of emergency attendances	206	38

- The most common reasons for admission in patients with an EHCP / PPC were infection and falls
- There were 7 admissions deemed inconsistent with EHCP, with no evidence wishes had changed
- 97.6% of patients who died, did so in their preferred place of care
- In those who survived 6 months post EHCP/PPC there was a significant reduction in inpatient bed days



Conclusions

- In the 6 months post EHCP rate of readmission was higher in patients with a recent inpatient stay, compared to those without. This is likely to reflect a higher risk of admission to hospital amongst recent inpatients.
- When the CGT formulated an EHCP or identified a PPC, death in the preferred place of care was achieved in the vast majority.
- Whilst admissions and length of stay were lower in the 6 months after EHCP/PPC, this is likely due to those having died not being re-admitted and regression to the mean, as well as any impact of GCT input.
- When looking solely at admission days in those who survived 6 months or more post EHCP / PPC, a reduction in inpatient bed days was observed.

Limitations and Recommendations

- An adequately power randomised controlled trial would be needed to assess the full impact of ECHP on hospital admission rates and costs.
- However if admission avoidance is a primary aim, patients who have not had recent hospital admissions seemed to gain most benefit from EHCP and PPC suggesting we should also be targeting complex elderly patients in the community.
- The data gained from this audit will be shared with the Community integrated teams who are in the process of taking over much of the care planning work previously undertaken by Sunderland Royal Hospital CGT.

References

1) What we know now. National end of life care intelligence network, 2014

2) Tevendale, Future Hospital Journal, 2016

3) Northern England Strategic Clinical Network, Deciding right