Proactive Elderly Advance Care Planning (PEACE) for nursing home residents

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Outcomes

- Understand the principles of Advance Care Planning
- Understand the process of ACP for nursing home residents in hospital
- To be able to discuss the outcomes and potential benefits for residents, relatives and care providers
Advance Care Planning

- A process of discussion between an individual, their care providers, and often those close to them, about their future care. The discussion may lead to:
  - An advance statement
  - An advance decision to refuse treatment
  - The appointment of a personal welfare LPA
Background

- Advance Care Planning National Guidelines (RCP 2009) – Note MCA central to making valid clinical decisions
  - only 10 – 62 % of ACP documents relating to hospital treatment contain sufficient information to direct care
  - No single tool recommended
  - ACP should be offered during routine clinical practice ideally in primary care
  - Discussions should be skilfully led
Advance Care Planning (ACP) using questionnaire (Expression of Healthcare Preferences) with older patients (n=95) in acute NHS setting

- 48% completed form
- 43% discussed their end-of-life healthcare preferences

(Schiff et al 2009)
Treatment and care towards the end of life:
good practice in decision making

Guidance for doctors

General Medical Council

Regulating doctors
Ensuring good medical practice
Nursing Home care in SE London

- 40 Nursing Homes for older people
- Nursing homes are mostly privately owned, but the NHS pays for the nursing care of residents
- 1751 beds
- 303 beds are registered to provide services for older people with mental health problems
Hospital attendance and admission

Issues arising from previous audits of nursing home residents admissions (Hayes, 2004) and A&E attendance (Hayes and Donnelly 2006, Hayes and Mucci 2007):

- Care home residents account for 9% of A&E attendances and 13% of admissions among >75’s
- **Acute problems** (respiratory / sepsis and injurious falls) are main cause for A&E attendance and admission, with high mortality during admission (17 - 34%).
- **End of life care** could be better managed within all sectors
- **Poor quality transfers of care** Some negative experiences of very frail care home residents.
Diagnosis of patients admitted from nursing homes

Hayes and Mucci 2007
Outcome 4 weeks post-discharge

- 11: At home
- 3: Readmitted
- 2: Died at home

Hayes and Mucci 2007
Aims of PEACE

- To improve communication in the transfer of clinical information between hospital and care home
- To provide an individualised document that records the suggested action plans on progression of illness which have been discussed with patients, relatives and carers by hospital specialists in the care of older people.
- Contribute to advance care planning
- Reduce inappropriate hospital readmissions
The PEACE document

- Jointly developed with GSTT
- Clinical plan / escalation levels developed at GSTT by Dr Steves for use with Minnie Kidd House
- Health care choices developed at King’s by Dr Jane Evans, Nicky Hayes and the CHST from earlier work by Dr Murtag
- Feasibility and pilot studies across both Trusts with evaluation supported by the Modernisation Initiative
Suggested Action on Progression of Illness
Possible developments identified
Four action categories
- Intensive
- Hospital
- Home
- Comfort
Individual advice – specific to development
Mental capacity
Views of significant others
  Record of discussions with next of kin or representative
  Spiritual needs
Health care choices
Discuss SAPI
Complete health care choices if possible and as far as patient wishes
King’s pilot study 2009 – 2010

- 20 patients discharged with PEACE over 4 months
- 80% (N=16/20) followed up at two weeks after transfer.
- 69% (N=11/16) of PEACE documents were in place in the nursing notes.
- ACPs had further been developed from PEACE in 73% (N=8 /11). None of these residents were readmitted to the discharging hospital to date
- Of those residents whose ACPs were not further developed, 37.5% (N= 3/8) were readmitted inappropriately (palliative plans), and 25% (N=2/8) were readmitted appropriately as judged by their original PEACE document in 3 months
PEACE follow up audit
July – October 2011

- PEACE document completed by medical staff and Specialist Nurse for patients discharged from HAU and MAU wards between July 2011 and October 2011 (4 months)
- Patients followed up from one week post discharge.
- 1 patient had home visit 76th day post discharge (11th week) to ascertain the continuity of ACP in the community
Results

- 13 patients had a PEACE document completed. 1 patient died in hospital prior to discharge.
- 12 patients were discharged with PEACE document to a care home.
- All followed up from one week post discharge.
- 10 patients had ACPS developed for them in the care home supported by Community Palliative team and GSF facilitators in the care home in Lambeth, Southwark and Lewisham.
- 2 patients were discharged out of borough.
- Approximately 30 patients were discharged with no PEACE document during the same period.
## Results

<table>
<thead>
<tr>
<th></th>
<th>PEACE</th>
<th>No PEACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>85YRS</td>
<td>84.3YRS</td>
</tr>
<tr>
<td>Gender</td>
<td>42%(male) 58%(Female)</td>
<td>53%(male)47%(female)</td>
</tr>
<tr>
<td>READERMISSION</td>
<td>0</td>
<td>17% (5/30)</td>
</tr>
<tr>
<td>MORTALITY</td>
<td>58%(7/12)</td>
<td>20%(6/30)</td>
</tr>
</tbody>
</table>
# Readmissions

<table>
<thead>
<tr>
<th></th>
<th>Readmission</th>
<th>No readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEACE</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>NO PEACE</td>
<td>5</td>
<td>25</td>
</tr>
</tbody>
</table>
Case study
Mr A J admitted with dehydration, hypertension, hypothermia
PMH COPD, macrocytic anaemia, advanced dementia, UTI
(recent admission)
On long term oxygen
Persistent left lower lobe consolidation – no malignancy

Treated IV fluids
Delayed swallow, eating and drinking small amounts
# PEACE for Mr A J

<table>
<thead>
<tr>
<th>Possible developments</th>
<th>Action category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration due to delayed swallow</td>
<td>Home</td>
<td>Follow SALT advice on positioning. On puree diet and sips, position upright. If fatigue noted allow to rest then resume feeding.</td>
</tr>
<tr>
<td>Dehydration due to reduced oral intake</td>
<td>Home</td>
<td>As above. Allow plenty of time to help Mr A J. Review of ACP is recommended re appropriateness of future hospital admissions for this.</td>
</tr>
<tr>
<td>Recurrent infections</td>
<td>Home</td>
<td>Consider referral to palliative team should future deterioration occur.</td>
</tr>
</tbody>
</table>
Outcome

Transferred home
Follow up visit planned 2/52 after discharge
Home phoned – concerned that not eating and drinking
GP supported care
Advance care plan reviewed at care home
RIP peacefully 27-05-10
Key points

- Team work and communication are vital
- Clinical team identify patients at MDM
- Medical team have key role in completing PEACE medical information and discussing with patient or representative
- Discharge coordinator and nursing team have key role in communicating with nursing home and supporting process
Any questions or comments?

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References / further information

- Mental Capacity Act 2005 Code of Practice
- Gold Standards Framework ‘prognostic indicator’ (www.goldstandardsframework.nhs.uk)
- Changing Gear – guidelines for managing the last days of life in adults (2006), National Council for Palliative Care
- End of Life Care Strategy – Promoting High Quality Care for All Adults at the End of Life (2008) DH, England (www.dh.gov.uk)