London Ambulance Service NHS Trust

A clinical audit examining End of Life Care in the London Ambulance Service

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Authors:
Frances Sheridan, Clinical Audit Officer
Georgina Jones, End of Life Project Co-ordinator / Paramedic

Clinical Advisors:
Dave Whitmore, Senior Clinical Advisor to the Medical Director
Mark Faulkner, Paramedic Advisor to the London Trauma Office & Clinical Advisor to the Procurement Department

frances.sheridan@lond-amb.nhs.uk
Clinical Audit & Research Unit, Medical Directorate,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London
SE1 0BW

Executive Summary

Background

In 2010, Healthcare for London published 'The end of life care good practice guide' which aims to implement a model of care that will enable a greater proportion of terminally ill patients to be cared for and die outside of hospital, in line with their wishes, by March 2013. The London Ambulance Service NHS Trust (LAS) will play a critical role in achieving this goal. There is currently little guidance given to crews about caring for patients who are nearing the end of their life. It is important that crews are trained to give the best possible care for this patient group and to ensure that the most appropriate referrals are made for these patients.

This clinical audit aimed to assess: the knowledge and confidence crews have regarding patients who are at the end stage of a terminal illness, and the patient care provided to end-stage terminally ill patients by the LAS. While identifying areas of good practice, this clinical audit also aimed to identify ways in which care could be improved.

Methodology

This clinical audit was conducted by the Clinical Audit and Research Unit (CARU) focussing on the care given to patients in three complexes: Bromley, Fulham and Hillingdon. A three stage clinical audit was undertaken comprising of: a baseline retrospective clinical audit; a questionnaire, and a prospective clinical audit.

In the baseline retrospective clinical audit, fifty cases from March to August 2010 with an incident or illness code associated with end of life care were selected through systematic sampling. These patients were attended by crews from Hillingdon or Bromley Complex. Data was collected from Patient Report Forms (PRFs) and the Patient Special Needs Locality database.

A questionnaire was distributed to staff at Hillingdon, Bromley and Fulham Complexes following the baseline retrospective clinical audit, to find out what knowledge and confidence staff had in treating this patient group. Results from the questionnaire were fed back to staff in posters displayed on stations.

Finally, a prospective clinical audit was conducted at Hillingdon, Bromley and Fulham Complexes. Data was collected from March to September 2011. These incidents were then audited against consensus standards.

Results

Of the 50 cases from the retrospective clinical audit, only 4% of patients had an out-of-hours form (LA225) registered on the LAS Patient Special Needs Locality database. The LAS attended 48% of patients outside the hours of 9am-5pm, Monday to Friday. The attending ambulance crew conveyed 88% of patients; 27% of these were taken to a hospice for palliative care, and 73% to A&E. When the patient was not being attended to at the request of a healthcare professional, 38% of crews consulted with the patients' GP or a member of their palliative care team.

Of the 61 questionnaire respondents, 53% stated they had 'very low' or 'some confidence' in treating this patient group. When asked to explain low levels of confidence, respondents said they felt they needed more training specifically focussing on alternative care pathways, evidence of terminal illness and DNA-CPR orders.

In the prospective clinical audit of 30 cases, the ambulance crew reported that they had considered whether the patient was experiencing pain and discomfort for 83% of patients, with subsequent action being taken for 73% of these patients. The patients' wishes were not documented for 79% of patients but the patients' diagnosis and prognosis was clearly documented for 97% of patients. Referrals were felt to be appropriate for 93% of patients and 7% had an LA225 registered on the Patient Special Needs Locality database.

Recommendations

1. The LAS should aim to increase staff knowledge and confidence in their assessment and treatment of patients with an end-stage terminal illness.

2. The LAS should have an increased number of LA225 forms registered on the Patient Special Needs Locality database. Clinical Support Desk staff should be able to access all palliative care patient plans to ensure correct management as per patient wishes.

3. Crews should be able to access telephone numbers for other health care professionals involved in the patients' care, particularly out-of-hours. Crews should be encouraged to consult with the patients' GP or a member of their palliative care team when deciding on a course of action.

4. Crews should be reminded about the correct use of PRF illness codes in relation to end of life care so that incidents are coded correctly as such and not only capturing the presenting complaint.

5. Crews should be informed of the findings of the clinical audit.

6. CARU should conduct a re-audit to assess compliance to the end of life care after the above recommendations have been implemented.

Background

In order to improve the care given to terminally ill patients at the end of their life, Healthcare for London produced 'The end of life care good practice guide' (2010). One of the aims of the guide is to implement a model of care which will enable a greater proportion of terminally ill patients to be cared for and die outside of hospital, in line with their wishes, by March 2013. The report outlines the critical role that the London Ambulance Service NHS Trust (LAS) will play in achieving this goal. The LAS not only acts as a transport provider to these patients, but provides care in their own homes in emergency situations and when the patient has no out-of-hours care plan. Approximately 75% of the week is outside normal working hours; therefore it is vital a high quality service is available to patients during this time.

The Department of Health's End of Life Care Strategy (2009) defines a marker of the quality of care provided to patients at the end of their life as measures and processes are in place to ensure that the patients' wishes have been identified by care providers in the community, allowing patients to die at home if they wish to do so. Improved co-ordination between patients and care providers means that at the time of death, more patients are able to be cared for/die in their preferred place. As a care provider, it is important that the LAS store and communicate information on this patient group to achieve optimal care and as such the LAS is collaborating with the Coordinate My Care project to introduce a pan London electronic register for end of life care plans (The Royal Marsden, 2011). The LAS currently use out-of-hours forms (LA225, see Appendix 1) completed by GPs and Palliative Care Teams which contain Advanced Care Plans and Do Not Attempt Resuscitation (DNA-CPR) orders. These forms also provide information to ambulance staff giving an overview of the patients' condition and care plan, such as management of complications or their preferred place of care. This action by the LAS supports the aims of the Gold Standards Framework (GSF, 2012). In 2008, the LAS identified that there is a risk that Patient Specific Protocols and LA225's may not be triggered by the call taker when the patients' address is identified during the 999 call (LAS, 2008). Since this risk was identified the LAS have taken steps to ensure that staff on the Clinical Support Desk (CSD) can access and update Patient Specific Protocols and control room staff have been issued with advice to ensure that the information from these protocols is checked and passed onto crew staff. It is important that the LAS take measures to ensure information regarding the patient is communicated to the crew who attend to ensure that the optimal care is achieved for the patient.

The LAS does not currently offer formal training to staff in the treatment of end-stage terminally ill patients but guidance has been issued to staff on DNA-CPR orders and resuscitation decisions via internal newsletters and bulletins. The Joint Royal Colleges Ambulance Liaison Committee Clinical Practice Guidelines for use in UK Ambulance Services (JRCALC, 2006) focus on termination of resuscitation only and do not extend to the general management of these patients. It is important that crews are trained to give the best possible care for this patient group and to ensure that the most appropriate referrals are made for these patients.

Aims & Objectives

The objective of this clinical audit was to assess the patient care provided to end-stage terminally ill patients by the LAS. This clinical audit aimed to assess the knowledge crews have regarding patients who are at the end stage of a terminal illness, and confidence levels of crews in their treatment of these patients. This clinical audit also aimed to identify areas of good practice in the treatment given to this patient group, and if necessary, identify ways in which care could be improved.

Methodology

Design

A three stage clinical audit was undertaken of the care given to end-stage terminally ill patients by the LAS.

Initially, a baseline, retrospective clinical audit was conducted. There were 255 cases identified from March to August 2010 that were given an illness code of: palliative care; cancer; end of life care – cancer; end of life care - organ failure, or an incident code of end of life care. Fifty cases were selected through systematic sampling in order to get a broad picture of the care delivered to this patient group by the LAS. These were all patients attended by crews from two initial complexes (Hillingdon and Bromley). These two complexes were chosen for the clinical audit as Bromley Complex is known to have good networks for end-stage terminally ill patients with St Christopher's Hospice providing care for many patients in this group within the area, and Hillingdon Complex is not known to have many networks for this patient group. Data was collected from Patient Report Forms (PRFs) and the Patient Special Needs Locality database, a system which stores LA225 forms and adds a flag (warning note) to the address so crews can be made aware that there is additional information available to assist them in patient care. This data was audited against standards of care derived from LAS local guidance and the Healthcare for London's end of life care good practice guide.

After reviewing baseline results it was decided to add a third complex (Fulham) to get a broader picture of end of life care delivered to patients across the service. A questionnaire was distributed to staff at Hillingdon, Bromley and Fulham Complexes to find out what knowledge and confidence staff had in treating this patient group (see appendix 2). These questionnaires were sent to the Ambulance Operations Manager or Team Leader championing the clinical audit project at each complex so that they could be distributed to staff. Staff at each complex were asked to put completed questionnaires into a collection box located on each station. Collection boxes were then emptied by the clinical audit project champion and returned to the Clinical Audit and Research Unit (CARU). Results from the questionnaire were fed back to staff in posters displayed on stations (see appendix 3).

Finally, a prospective clinical audit was conducted across the three complexes. The decision to conduct a prospective clinical audit was made in light of anecdotal concerns by Clinical Advisors and clinical audit staff that the end of life care incident and illness codes were not consistently used correctly when crews were attending patients presenting with an end-stage terminal illness. Concerns were also raised that the illness and incident codes used by the LAS to identify this patient group may not account for some patients who present with less common end-stages terminal illness types. Data was collected from March to September 2011 through crew identified cases (see case entry form Appendix 4), and cases identified by restricted duties staff and clinical audit project champions on each complex who sorted through PRFs to ensure no cases were missed. These incidents were then measured against consensus standards formed by Clinical Advisors to the Medical Director due to a lack of guidelines available for ambulance staff regarding the management of this patient group.

Clinical audit standards

Adherence to the following standards of care derived from LAS local guidance, the Healthcare for London End of Life Care good practice guide and LAS Medical Directorate clinician consensus was measured.

Aspect of Care	Target	Exceptions	Definitions & Instructions
Palliative care/End of life care hand over form (LA225) completed	100%	None.	End of life care good practice guide – Healthcare for London (March 2010)
Patient care plan followed (as specified on the LA225)	100%	No LA225 for the patient.	End of life care good practice guide – Healthcare for London (March 2010)
DNA-CPR request followed	100%	Patient did not have a DNA-CPR; No evidence of the patient's DNA-CPR; Patient had a DNA-CPR but was not in cardiac arrest whilst in the care of the ambulance crew.	LAS Clinical Update (December 2008)

Table 1: Stage one, retrospective clinical audit standards

Aspect of Care	Target	Exceptions	Definitions & Instructions
Documentation of consideration of pain and discomfort.	100%	Patient unconscious.	Clinician consensus – LAS Medical Directorate (December 2010).
Where pain or discomfort is identified crews took action* to try and correct it.	100%	Patient declined; Patient has no obvious pain or discomfort.	Clinician consensus – LAS Medical Directorate (December 2010).
Documentation of the patient's wishes.	100%	Patient unable to communicate; Patient transfer.	Clinician consensus – LAS Medical Directorate (December 2010).
Clear documentation of diagnosis and prognosis.	100%	Diagnosis and prognosis not known; No documentation on scene.	Clinician consensus – LAS Medical Directorate (December 2010).
Referral appropriate to presenting condition.	100%	Health care professional requested the referral.	Clinician consensus – LAS Medical Directorate (December 2010).
Out-of-hours form (LA225) for the patient on the LAS database and communicated to ambulance crew.	100%	Patient is in a nursing home.	Clinician consensus – LAS Medical Directorate (December 2010).

Table 2: Stage two, prospective clinical audit standards

*Action to correct pain, examples include: analgesia, repositioning patient, ensuring bladder empty.

Data analysis
Data was entered into Statistical Analysis Software (SPSS), and analysed using descriptive statistics.

Results

Stage One: Retrospective clinical audit (50 cases)

Patient demographics
Of the 50 patients in the sample, 58% (n=29) were female and 42% (n=21) were male. Patients' ages ranged from 33 to 92 years, with a median age of 75 years.

Palliative care/End of life care hand over form (LA225) completed
Only 4% (n=2) of patients had an LA225 form registered on the LAS Patient Special Needs Locality database. The LAS attended 48% (n=24) of patients outside the hours of 9am-5pm, Monday to Friday.

Patient Care Plan followed (as specified on the LA225)
Two patients had an LA225 form registered on the LAS Patient Special Needs Locality database that stated that the care plans for the patients advised conveyance to a hospice. Both patients were conveyed to a hospice in line with their care plan. There were no LA225 forms registered for the remaining 48 patients (96%).

As there were no LA225 forms registered for the majority of patients, some crews sought out this information by other means. The LAS attended to 48% (n=24) of patients at the request of a healthcare professional, therefore a care plan would not have been required for these patients. When the patient was not attended to at the request of a healthcare professional, 38% (n=10) of crews consulted with the patients GP or a member of their palliative care team.

The attending ambulance crew conveyed 88% (n=44) of patients; 27% (n=12) of these were taken to a hospice for palliative care, and 73% (n=32) of patients were taken to A&E. Six patients were not conveyed by the attending ambulance crew. Without care plans it was not possible to tell if the patients' destination was appropriate and in line with their preferred place of care.

DNA-CPR request followed
The LAS were told that four patients had a DNA-CPR order in place. Three patients were not in cardiac arrest whilst in the care of the ambulance crew and therefore this element of their plan was not applicable. One of these patients was in cardiac arrest when the ambulance crew arrived and therefore the DNA-CPR order applied in this case. The ambulance crew sought advice from the CSD as there was no DNA-CPR evidence on scene. The crew were advised that if there was evidence that the patient's terminal illness had lead to their cardiac arrest, this was sufficient not to resuscitate the patient. The ambulance crew acted appropriately in this case by not resuscitating the patient.

Stage Two: Ambulance Staff Questionnaire

Three hundred and sixty questionnaires were sent to staff at Hillingdon, Bromley and Fulham Complexes. There was a 17% (n=61) response rate to the questionnaires (Hillingdon n=6, Bromley n=16, Fulham n=28 and 1 questionnaire was returned but the respondents complex could not be identified). Questionnaires were well completed and responses sent by staff across the three complexes were similar.

Question 1. Approximately how many 'end of life care' patients have you attended in the past 6 months?

One respondent did not state how may 'end of life care' patients they had attended in the last 6 months. Of the remaining 60 responses, 32% of respondents (n=19) had attended no patients, 65% (n=39) had attended 1-5 patients, 2% (n=1) had attended 6-10 patients and 2% (n=1) had attended 16 or more. Figure 1 shows the responses in answer to question 1.

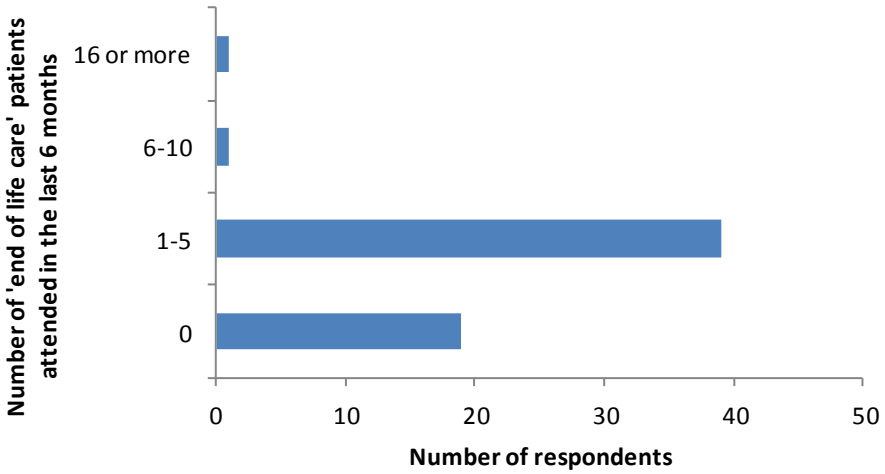

Figure 1: Responses when asked how many 'end of life care' patients they had attended in the last 6 months.

Question 2. Please list the medical conditions you are aware of that lead to a terminal diagnosis e.g. cancer.

Cancer was the most frequently documented terminal diagnosis (n=52). Motor Neurone Disease, COPD and Heart Failure were also frequently documented as medical conditions that could lead to a terminal diagnosis. Table 3 shows the medical conditions that can lead to a terminal diagnosis most frequently documented by questionnaire respondents.

Medical Condition	Frequency of documentation
Cancer	52
Motor Neurone Disease	29
COPD	22
Heart Failure	21
HIV/AIDS	17
Renal Failure	10
Organ Failure	10
Liver Failure	9
Multiple Sclerosis	8
Alzheimers/Dementia	7
Kidney Failure	5
Parkinsons	5
Stroke	4
Elderly/Frail	4
Huntingtons	3
Brain Tumour	2

Table 3: Crew defined medical conditions that could lead to a terminal diagnosis

Question 3. Please rate how confident you feel in your ability to treat 'end of life care' patients?
Two respondents did not indicate how confident they felt in treating this patient group. Most respondents stated they had some or reasonable confidence in treating this patient group. Only two respondents stated they had very high confidence in treating this patient group. Figure 2 shows the confidence ratings expressed by the remaining 59 respondents.

Figure 2: Confidence ratings of questionnaire respondents.

Questionnaire respondents that stated they had 'very low' or 'some confidence' in treating this patient group were asked to explain why, and what they thought might help to improve their confidence. Overall respondents said they would benefit from training, specifically focussing on:

- When it would be appropriate to support the patient to remain at home with appropriate symptom management and when to transport them to A&E.
- Alternative pathways for this patient group, especially when the LAS are called out-of-hours.
- What constitutes sufficient evidence of a terminal illness that would inform ambulance staff's resuscitation decision?
- Training on DNA-CPRs with examples.

Stage Three: Prospective clinical audit (30 cases)

Thirty eight cases collected over a four month period were identified by crews and end of life care clinical audit champions as attendance to an end-stage terminally ill patient. Two cases were excluded from the clinical audit as a nurse was on scene when the crew arrived, and acted as the senior practitioner caring for the patient. Six cases were excluded as they were deemed not to be 'end of life care' following clinical review, including, amongst others, a patient who had suffered a suspected stroke and a patient with mental health problems. The remaining 30 cases were assessed.

Patient demographics

Of the 30 patients in the sample, 40% (n=12) were male and 60% (n=18) were female. Patients' ages ranged from 38 to 99 years, with a median age of 75 years. The most frequently documented illness codes were cancer (90) and other medical condition (47). Figure 3 shows the primary illness codes documented for patients.

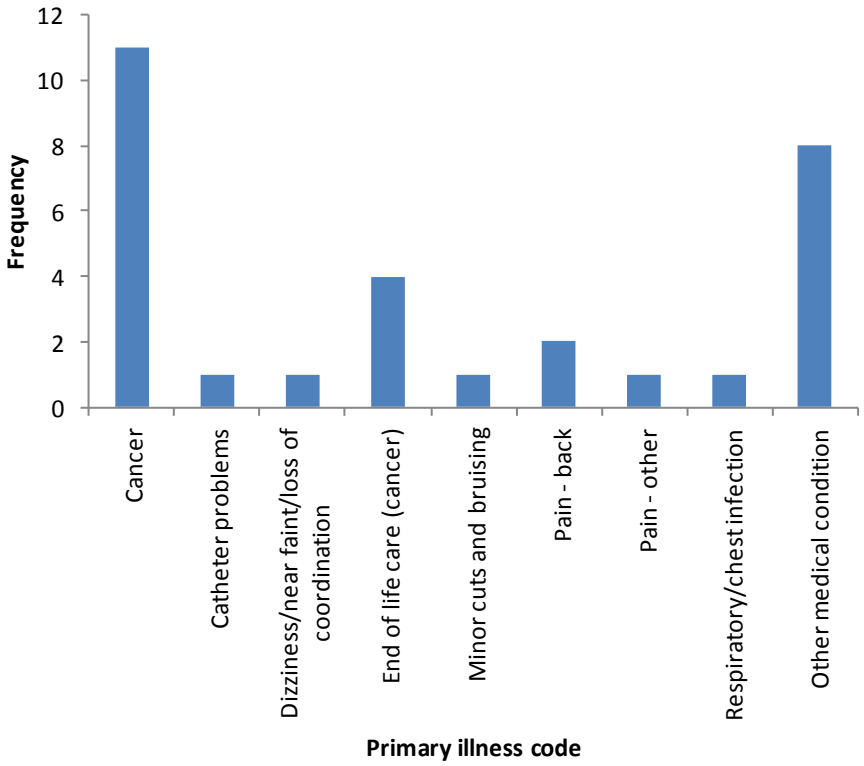

Figure 3: Primary illness codes documented for patients.

Documentation of consideration of pain and discomfort

The ambulance crew documented that they had considered whether the patient was experiencing pain and discomfort for 83% (n=25) of patients. Consideration of pain and discomfort was not documented for 17% (n=5) of patients.

Where pain or discomfort is identified crews have taken action to try and correct it

It was not documented whether five patients were experiencing pain and discomfort, therefore the action taken to try and correct the patients pain could not be assessed. Eight patients had no pain or discomfort when assessed, and therefore no action was indicated. Two patients declined the analgesia offered by the crew (Entonox) to try and ease the patients' pain or discomfort. As both crews were A&E Support Staff they were unable to administer any additional analgesia and it is not documented if they offered to call a Paramedic for assistance or if they tried alternative methods of reducing the discomfort such as positioning.

Action had been taken to try and correct the pain or discomfort of the patient in 73% (n=11) of the remaining 15 cases. No action was taken to ease the pain or discomfort of 27% (n=4) of patients. Pain relief was not given to one of these patients as the crew documented that the patient had brain swelling and queried whether this was a contraindication to analgesia. In this case the crew should have called the CSD for advice.

Documentation of the patients' wishes

Two patients were being transferred between units and therefore it was not necessary for the ambulance crew to document the patients' wishes as it would not have affected the care delivered to the patient in this instance. Wishes were documented for 21% (n=6) of the remaining 28 patients. The patients' wishes were not documented for 79% (n=22) of patients.

Clear documentation of diagnosis and prognosis

The patients' diagnosis and prognosis was clearly documented for 97% (n=29) of patients. There was no documentation of diagnosis and prognosis for one patient.

Referral appropriate to presenting condition

A health care professional requested the referral of 15 patients. A clinical review was conducted to decide if the referral that the ambulance crew made for the remaining 15 patients was appropriate. The referral was considered appropriate for 93% (n=14) of patients (A&E (n=9); Hospice (n=4); Referred to GP/Palliative Care Team (n=1)). It was not possible to tell whether the referral for the remaining patient was appropriate due to insufficient documentation. Figure 4 shows the referrals made for the 15 patients for whom a health care professional had not requested the referral.

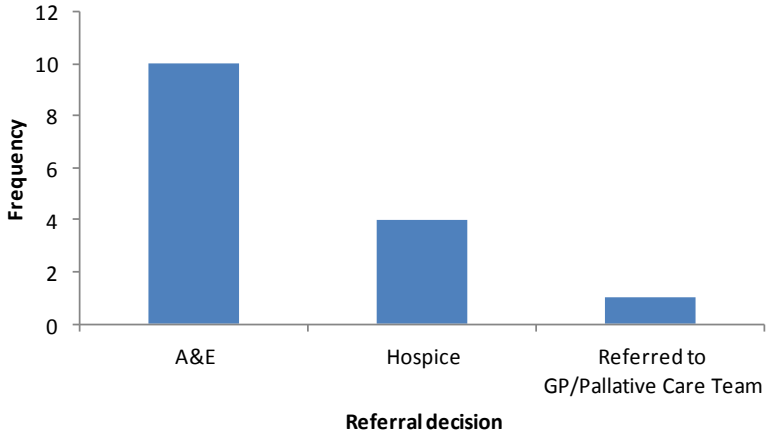

Figure 4: Referral decisions made by crews.

Out-of-hours form (LA225) held on the LAS database and communicated to the ambulance crew
Two patients in the sample were in a nursing home and therefore would not have an individual LA225 registered on the LAS's Patient Special Needs Locality database. Locality information cannot be stored electronically for individual patients in a care home due to the large numbers of people living there. CSD are able to access a list of patients at the care home who have a plan in place and therefore obtain the individual patients' paper LA225. This was not assessed as part of this clinical audit.

Of the remaining 28 patients, 7% (n=2) had an LA225 registered on the Patient Special Needs Locality database. For one of these patients, the information registered on the Patient Special Needs Locality database about the patient's care plan was shared with the crew prior to their attendance by the CSD. Attendance to the other patient was requested by a health care professional and therefore instructions for the patients care were given to the ambulance crew by the professional requesting LAS attendance, via the LAS Emergency Operations Centre.

Discussion

This clinical audit identified both areas of good practice and areas where care could be improved. The retrospective clinical audit found that when a crew attendance was not at the request of a health care professional, some crews chose to consult with the patients GP or a member of their palliative care team when deciding on a course of action. This shows that crews are considering patients' care plans when attending end-stage terminally ill patients and engaging with the other health care professionals involved in the patients' care. All crews should be encouraged to discuss the best course of action for the patients' care with their GP or palliative care team if this has not already been made clear in a patient care plan that has been shared with the crew. This can be achieved through a discussion with crews when training is delivered and highlighted by publishing a reminder to crews.

The questionnaire given to staff which investigated the knowledge and confidence staff had in treating end stage terminally ill patients revealed that staff were aware of the wide variety of conditions that can lead to a terminal diagnosis. However, results of the questionnaire also showed that most staff only had 'some confidence' when treating this patient group and felt that further training was needed to improve their confidence. The LAS should aim to increase the confidence of staff in caring for patients who have an end-stage terminal illness through the delivery of training.

The prospective clinical audit found that an assessment of pain or discomfort was conducted for the majority of patients, however there was room for improvement. An assessment of pain or discomfort should be conducted for all patients who present to the LAS with an end-stage terminal illness to allow the crew to decide on the correct management for the patient. Whilst action was taken to manage the patients' pain or discomfort in most cases, there is still a need for improvement and an increased awareness amongst staff of actions in addition to analgesia to bring relief, such as a change of position and addressing emotional pain. This area of care can be improved through offering additional training for crews on pain management and specifically pain in end stage terminally ill patients. Crews should be reminded that the CSD should be contacted where the correct management of the patient is in doubt due to their condition.

It was found that information registered on the LAS Patient Special Needs Locality database was communicated with the ambulance crew when it was indicated in two cases and the patient was conveyed to a hospice in line with care plan on the LA225 held for the patient. However, only very

small numbers of patients had an LA225 registered on the Patient Special Needs Locality database. If the number of LA225's registered with the LAS for patients who have a terminal diagnosis could be increased, more patients could be managed by crews according to their wishes and plans made. With the introduction of Coordinate My Care register in 2012 the LAS should be able to access a considerably greater number of plans and enable this to happen.

The wishes of just over a fifth of patients were documented. It is important that the ambulance crew ascertain the wishes the patient has for their care as this may affect the treatment provided by the LAS and other health care professionals as the patient nears their end of life. The LAS should ensure that crews are reminded of their responsibility to discuss the patients' wishes for their care with them, and provide guidance through training on how this should be done. The majority of patients who have an end stage terminal illness will have a care plan in place. If the patient does not have a care plan in place it is important that the crew acknowledge this in their documentation. The patient may have already expressed wishes for their care to another health care professional and therefore this information may be included in the patients' notes. Crews should be encouraged to consult with other healthcare professionals involved in the patients' care and if they are in possession of the patients' notes at any time they should be reminded that this should also be documented.

Good practice was identified by crews when documenting a clear diagnosis and prognosis for the patient. The clinical audit also identified that the majority of crew decisions regarding the place of conveyance resulted in A&E.

Limitations

As part of this clinical audit it was not assessed whether the patients' presenting complaint was related to the palliative care condition, or if the LAS were called as a result of a co-morbidity or accident. Therefore A&E may have been appropriate in the later cases, however if the patients' terminal illness was the reason for the call A&E may not have been the most appropriate destination for the patient.

Recommendations and Actions

Recommendation Number	Recommendation	Action/ Means	Responsibility	Deadline
1	The LAS should aim to increase staff knowledge and confidence in their assessment and treatment of patients with an end-stage terminal illness.	As part of agreed content for Core Skills Refresher 3 training the Department of Education and Development should roll out an End of Life Care training package to all crews, including: • How to identify patients who are at the end-stage of their terminal illness. • How to discuss patient's wishes for their care. • The identification of pain and discomfort in patients with end-stage terminal illnesses and what actions can be taken to ease this. • Examples of DNAR-CPR orders and reminders for crews regarding the examples of evidence available to establish a terminal illness • The use of alternative care pathways for patients with an end-stage terminal illness. • The need to contact the patient's palliative care team and the CSD for support when making decisions about patient management. • The importance of assessing and managing patients' pain or discomfort • The need to routinely ascertain and document the patients' wishes for their care. • The need to document whether a care plan exists for the patient and if they were in possession of the patients' notes at any time whilst the patient was in their care.	Assistant Director of Professional Education and Development, Gill Heuchan.	1,000 crews trained by April 2013.
		The Service Development Team in conjunction with the Medical Directorate should develop an advanced education package for Clinical Support Desk staff.	Service Development Manager, Emma Williams.	April 2012.

Recommendation Number	Recommendation	Action/ Means	Responsibility	Deadline
2	The LAS should have an increased number of LA225 forms registered on the Patient Special Needs Locality database. Clinical Support Desk staff should be able to access all palliative care patient plans to ensure correct management as per patient wishes.	There is currently no department responsible for flagging addresses for registered care plans. This should be raised as a risk and an LA167 Risk Assessment Form should be submitted to the Audit and Compliance Manager with a view to including it on the LAS Corporate Risk Register. The Medical Directorate should ensure that CSD staff can access palliative care plans following the adoption of the Coordinate My Care database across London.	Head of Clinical Audit and Research Unit, Rachael Donohoe. Medical Directorate Fionna Moore.	March 2012. From April 2012.
3	Crews should be able to access telephone numbers for other health care professionals involved in the patients' care, particularly out-of-hours. Crews should be encouraged to consult with the patients' GP or a member of their palliative care team when deciding on a course of action.	The Medical Directorate should publish guidance in the LAS Clinical Update to instruct crews to call the CSD for further support and advise crews to contact the patients' palliative care team.	Medical Directorate Fionna Moore.	June 2012.
4	Crews should be reminded about the correct use of PRF illness codes in relation to end of life care so that incidents are coded correctly as such and not only capturing the presenting complaint.	The LAS should review current illness and incident codes and issue new guidance to crews.	Service Development Manager, Emma Williams.	December 2012.
5	Crews should be informed of the findings of the clinical audit.	CARU should issue crews with a poster to highlight their good practice in making appropriate referrals in line with care plans, and areas for improvement.	Head of Clinical Audit and Research Unit, Rachael Donohoe.	March 2012.
6	CARU should conduct a re-audit to assess compliance to the end of life care after the above recommendations have been implemented.	CARU should conduct a re-audit for end of life care.	Head of Clinical Audit and Research Unit, Rachael Donohoe.	June 2014.

Table 4: Recommendations and actions for improvement to the care provide to patients who are at the end-stage of their terminal illness

References

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APPENDIX 1
LA225 Out-of-hours Form

London Ambulance Service NHS
NHS Trust

LA225 - Palliative Care / End of Life Care Handover Form -

Please Complete Electronically and email to ooh.las@nhs.net
or as a secondary option complete form, print and fax to London Ambulance on **020 7921 5287**

FAX TO -- OOH GP: FAX:

Also sent to other: FAX:

Are you **UPDATING** information already held? If YES please tick here ☐ and fill in relevant updated information e.g. Address Change.

CONFIDENTIAL MEDICAL INFORMATION: Please update as required.

Patient details	**Carer details**	**GP details**
Name: DOB/age: Sex: Address: Tel(s): NHS No:	Name: Approx age: Address: Tel(s): Relationship to pt:	Name: Practice/code: Address: Tel (in hours): Fax: **Tel (ooh):**

Unless it is a medical emergency please contact the nursing service before considering admission.
For specialist end of life care/ palliative advice contact the Named Team.

District Nursing Service	Night Nursing Service	Specialist Palliative Care Advice/Hospice Contact
District Nurse: Address: Tel:	Base: Tel: **Mobile:**	Provider: **Address:**

Fax: Working Hours: Mobile(week days): Mobile(w/es & BHs):	**Fax:** Working Hours:	Tel: Fax: CNS Name: Community Team Contact Tel:
Hospital Team Involved Hosp: Consultant: Tel: Fax:	<u>Further Info</u> Is the patient on the practice's Gold Standards Framework Register: YES ☐ NO ☐ Is the patient on the Liverpool Care Pathway: YES ☐ NO ☐ Is there a Preferred Priorities for Care (PPC) Document in the house: YES ☐ NO ☐ Is the patient under direct care/supervision of a Hospice: YES ☐ NO ☐	

Medical information
Diagnosis and dates:
(Please enclose any other relevant medical summaries)

Patient aware of diagnosis: Yes ☐ No ☐ Carer aware of diagnosis: Yes ☐ No ☐

Is there an Advanced Directive or Advanced Care Plan? Yes ☐ No ☐ Where?

Consent of patient obtained for transfer of information Yes ☐ No ☐
Medicine Management

Has the patient been prescribed strong opioids? Yes ☐ No ☐
(Please give details)

Emergency drugs left in home (name and dosage) :

Syringe Driver, if needed available from:

Plans for OOH period urgent community care (District Nurse / Marie Curie / Hospice Outreach etc):

End of Life Phase

Is death anticipated? Yes ☐ No ☐ How Soon?

Patient Priority Final Place of Care e.g. Home / Hospice etc.

Has Resuscitation been discussed with the patient? Yes ☐ (please give details below) No ☐

Resuscitation discussed with the family / carer? Yes ☐ (please give details below) No ☐

In the event of cardiac arrest, should resuscitation commence? (For Clarity please type YES or NO)

Is there a signed Allow Natural Death / DNAR order in the house? Yes ☐ No ☐ (If YES Please state location below)

Other DNAR notes:

Cultural / Religious / Spiritual - Care of the Body after death

Form Complete by: Name: Role:

Date:

Email: Phone: Fax:

Locality info: Index:

APPENDIX 2
End of Life Care Questionnaire

1. Approximately how many 'end of life care' patients have you attended in the past 6 months? (Please tick)

☐	☐	☐	☐	☐
0	1-5	6-10	11-15	16 or more

2. Please list the medical conditions you are aware of that lead to a terminal diagnosis e.g. cancer.

3. Please rate how confident you feel in your ability to treat 'end of life care' patients? (Please tick)

☐	☐	☐	☐	☐
Very low confidence	Some confidence	Reasonable confidence	Sufficient confidence	Very high confidence

If very low or some confidence, please explain why and what you think might help.

Thank you for completing this questionnaire.

If you have any comments please write them here or email me at frances.sheridan@lond-amb.nhs.uk

APPENDIX 3

London Ambulance Service NHS Trust

End of Life Care Clinical Audit

Feedback from Questionnaires

There was a 16% response rate to the questionnaires across Bromley, Fulham & Hillingdon.

Knowledge of medical conditions that can lead to a terminal diagnosis was varied. The following 'End of Life' conditions were documented:

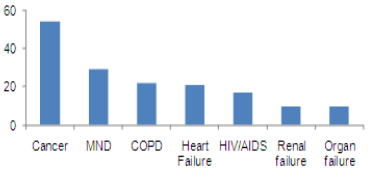


Figure 1*

The majority of respondents said they had **some confidence** in treating this patient group, 16% of respondents had **very low** confidence.

The feedback received to improve confidence in treating this patient group was that **training should be given**, specifically focussing on:

- When it would be appropriate to support the patient to remain at home with appropriate symptom management and when to transport them to hospital.
- Alternative pathways for this patient group, especially when the LAS are called out-of-hours.
- What constitutes sufficient evidence of a terminal illness that would inform the crews resuscitation decision.
- Training on DNA-CPRs with examples.

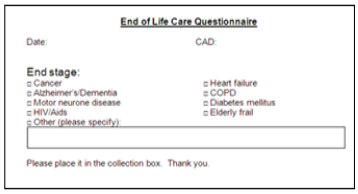
*Figure 1 shows the most frequently documented conditions and is not exhaustive.

Next Steps

The next step for this project is a clinical audit of PRFs where care has been given to 'End of Life' patients.

Complete a questionnaire. → Complete a case entry sheet for every 'End of Life Care' patient you attend. → Clinical Audit report will be produced.

Please complete a **case entry sheet** for every 'End of Life Care' patient you attend and place it in the collection box on station. An anonymous audit of these cases will be conducted.



End of Life Care Questionnaire

Date: CAD:

End stage:

- Cancer
- Alzheimer's/Dementia
- Motor neurone disease
- HIV/Aids
- Other (please specify):
- Heart failure
- COPD
- Diabetes mellitus
- Elderly frail

Please place it in the collection box. Thank you.

Aims

The aims of this clinical audit are to identify:

- Good practice in treating this patient group.
- Areas where improvement is needed.

Following a clinical audit of PRFs where care has been given to 'End of Life' patients, the questionnaire responses and clinical audit results will be combined to produce recommendations on how care given by the LAS can be improved.

Thank you in advance for your assistance with this project. Your input will help to improve care for 'End of Life' patients across London.

For further information please contact:
Clinical Audit & Research Unit
Tel: 020 7783 2512 Email: frances.sheridan@lond-amb.nhs.uk

APPENDIX 4

Case Entry Form

End of Life Care Questionnaire

Date: CAD:

End stage:
□ Cancer
□ Alzheimer's/Dementia
□ Motor neurone disease
□ HIV/Aids
□ Heart failure
□ COPD
□ Diabetes mellitus
□ Elderly frail

Please place it in the collection box. Thank you.