End of Life Care Audit: Dying in Hospital – SEPTEMBER 2015

See https://www.rcplondon.ac.uk/resources/end-life-care-audit-dying-hospital for updates

Headlines

Audit extended to include Wales

Thanks to additional funding received from Marie Curie Cancer Care, the upcoming End of Life Care Audit - Dying in Hospital has been extended to include Wales. Welsh NHS Health Board Chief Executives and clinical audit teams have been informed, and sites are invited to register by completing an audit registration form (available to download below) and returning this to: eolca@rcplondon.ac.uk by **Friday 5 June 2015**.

2015 audit details and a request for pilot sites

The March 2015 End of Life Care Audit newsletter is now available to download below. As well as providing additional details regarding the 2015 audit, this edition of the newsletter includes a call for volunteer sites to participate in the upcoming pilot audt, set to commence in April 2015.

Background

The End of Life Care Audit: Dying in Hospital is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. It is designed to ensure that the priorities for care of the dying person outlined in the document *One Chance to Get it Right* are monitored at a national level. National audit data will support end of life care commissioners, service providers and policymakers to audit the care and to facilitate quality improvement initiatives.

Over half of all deaths in England take place in hospital. Understanding the quality of care delivered in hospitals during the last days of life is important to drive improvements in the quality and productivity of services.

Priorities for care of the dying person (from *One Chance to Get it Right*)

The priorities for care are that, when it is thought that a person may die within the next few days or hours:

1. this possibility is recognized and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
2. sensitive communication takes place between staff and the dying person, and those identified as important to them
3. the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
4. the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
5. an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Aims and objectives of the End of Life Care Audit

The overarching aim of this audit is to improve the quality of care and services for patients who have reached the end of their life, in hospitals in England. This aim will be achieved through a project with the following objectives:

1. To build on the learning from previous care of the dying audits to date, preserving and further developing the most successful design features in order to maximise its quality improvement impact whilst moving away from a focus on a 'pathway'.
2. To achieve and maintain close alignment with relevant national guidance – *One Chance to get it Right*, NICE national guidelines and quality standards throughout the audit, as appropriate.
3. To consider how the experience of relatives and carers could be incorporated in the audit moving forwards and achieving a granularity that would enable the future comparison of providers of healthcare and address any potential for duplication.
4. To develop from the dataset markers of best practice for end of life care to enable comparison over time with the potential to be used in other national audits.
5. To enable improvements through the provision of timely, high-quality data that will enable the future comparison of healthcare providers, and comprise an integrated mixture of named trust, MDT and consultant-level reporting.

Scope of the audit

The audit will incorporate an organisational audit and a clinical audit.

The End of Life Care organisational audit dataset will address the key messages and recommendations from the National Care of the Dying Audit Hospitals, England 2014.

The End of Life Care clinical (case note review) audit dataset will address the key messages and recommendations from the National Care of the Dying Audit of Hospitals, England 2014, and the Priorities for Care of the Dying Person.

Involvement of those important to the patient

While the 2015 audit won't incorporate a survey of bereaved relatives' views, it will undertake a consultation with NHS trusts to assess whether post-bereavement surveys are being undertaken and, if so, what type of survey tools are being used. Dependent on the responses received, it may then be feasible to develop a short form/tool for use in future audit rounds.

For further information about the End of Life Care Audit please email EOLCA@rcplondon.ac.uk

Royal College of Physicians

Setting higher standards

End of Life Care Audit: Dying in Hospital
newsletter March 2015

Registration for the 2015 audit

Thanks to those of you who have already registered to participate in the 2015 End of Life Care Audit.

Those still wishing to register can do so by completing and returning the registration form attached with this newsletter. If accessing this newsletter online, please contact EOLCA@rcplondon.ac.uk to request a copy of the audit registration form.

Audit details for 2015

This will be a combined Clinical and Organisational audit. The 'Survey of Bereaved Relatives views' will not form part of the 2015 audit

Data entry will be via a secure online audit web-tool. Further details on how to access the tool and submit your audit data will follow in due course.

The inclusion/exclusion criteria for the clinical (case note review) audit will be as follows:

Include:

- all adult patients aged 18 years or above (at time of death), who died in hospital and had been under the care of the hospital trust for 4 or more hours prior to death from 1 May to 31 May 2015.

Exclude:

- deaths in the accident and emergency department if death is a result of an accident / untoward incident, deaths where suicide was suspected, deaths where overdose (including accidental) was suspected and deaths with an unknown cause
- all cases containing the following ICD-10 codes, clinically coded in any position within the finished consultant episodes (FCE's) of the last episode of care: acute myocardial infarction – I21, I22; pulmonary aneurysm – I281; sudden cardiac death – I461; aortic aneurysm – I71; injury, poisoning, other consequences of external causes – S00-T98; external causes – V01–Y98
- deaths occurring in a community or other hospital not directly managed by the trust being audited.

Pilot sites needed!

We are currently looking for volunteers to participate in a pilot audit, to be conducted in April.

The inclusion/exclusion criteria for the pilot audit will be as above; however you will only be required to audit the case notes of **five patients** that died in the month of **February 2015**, as well as completing the Organisational audit questions.

If your unit would like to participate in this pilot, or for any other queries regarding the audit, please contact us at EOLCA@rcplondon.ac.uk or by calling 020 3075 1347

Audit Timeline

Organisational audit data collection period	1-31 July 2015
Data entry period for Organisational audit ends	31 July 3015
Clinical (case note review) audit data collection period	1 July – 30 September
Data entry period for Clinical (case note review) audit ends	30 September
Individual site reports available to participants	February - March 2016
National report published	March 2016