Care of Dying Adults NG31 Re-Audit Apr-Jun 2024

Introduction

The ways in which people die varies widely. Some people remain mobile, largely self-caring and can continue to take oral medication and eat and drink up right up until their death; others die suddenly and unexpectedly. Some people may never experience any symptoms. People with progressive cardiac, pulmonary, neurological disorders, dementia or some cancers may spend several weeks or months in a gradual or intermittent decline. Although NICE guidance NG31 Care of Dying Adults at the End-of-Life guideline (NG31) focuses on the people who are thought to be in the last few days of life, for many people, especially those in a gradual decline, the principles of communication, shared decision-making and pharmacological care can be applied far earlier in their care. The guidance applies to all people at the end of life.

For some people who are entering the last days of life, mental capacity to understand and engage in shared decision-making may be limited. This could be temporary or fluctuating, for example it may be caused by delirium associated with an infection or a biochemical imbalance such as dehydration or organ failure, or it could be a permanent loss of capacity from dementia or other similar irreversible conditions. NG31 makes clear the duties of the multi-professional team regarding communication and involving those people important to the dying person. The guideline provides recommendations to help healthcare professionals to recognise when a person is entering the last days of life or may have stabilised or be improving even temporarily; to communicate and share decisions respectfully with the dying person and people important to them; and to manage hydration and commonly experienced symptoms to maintain the person's comfort and dignity without causing unacceptable side effects.

This re-audit sets out to examine the Hospice's compliance with QS144 – Care of dying adults in the last days of life which is based on NG31.

Aims

1. To assess compliance against the standards.
2. To identify areas of strength and weakness in our current practice/ documentation.

Methodology

Retrospective audit of 20 inpatient unit patient deaths and 15 community deaths in April – June 2024 utilising the National Audit of Care at the End of Life benchmarking audit tool. Data collection criteria have basis in the NICE Quality Standard QS144.

Standards

Standards are based on NICE Quality Standard 144 Hospice's care-of-dying-adults-in-the-last-days-of-life-pdf-quality standards March 2017.pdf :-

1. 100% dying adults in last days of life have daily monitoring of signs and symptoms
2. 100% dying adults in last days of life have individualised care plan
3. 100% dying adults in last days of life have care plan discussed with them and people important to them
4. 100% dying adults in last days of life have the care plan followed
5. 100% dying adults in last days of life have anticipatory prescribing needs assessed for symptoms likely to occur in last days of life
6. 100% dying adults in last days of life prescribed anticipatory medications with individualised indications for use, dosage and route of administration
7. 100% dying adults in last days of life have their hydration status assessed daily
8. 100% dying adults in last days of life have discussion about risks and benefits of hydration options

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Results - Introduction

In the period 01.04.2024 to 30.06.2024 there were 152 deaths of people referred to St Raphael's Hospice.

	Place of death				
Month	**Hospice**	**Nursing home**	**Home**	**Hospital**	**Total**
April 2024	13	4	22	14	53
May 2024	17	3	21	9	50
June 2024	13	4	17	15	49
Total	43 (28%)	11 (7%)	60 (39%)	38 (25%)	152

IPU 2024 data presented below reflects upon the 20 Hospice inpatients audited and CPCT 2024 on the 15 patients audited who died under the care of the community team (all in their own home) between 1st April and 30th June 2024. Patients were selected at random.

IPU 2022 data presented below reflects upon the 15 Hospice inpatients audited and CPCT 2022 on the 15 patients who died under the care of the community team (5 in a nursing home setting and 10 in their own home) between 1st October and 31st December 2022. One of the patients that died at home was never seen, so has been included for the demographic but not care plan details.

Data in the 2021 dataset reflects upon 8 inpatients and 10 community patients who died in May 2021. However, 2 patients from the community arm were admitted onto the IPU and died there. These 2 patients were excluded from the audit to reflect only 8 community patients and to avoid duplication of data.

Demographics

Age

	IPU 2024	IPU 2022	IPU 2021	Community 2021	Community 2022	Community 2024
Age Range (years)	**31-88**	47-93	63-87	58 - 92	49-92	**55 – 93**
Average Age at RIP	**70.3**	73.7	75	72.5	77.4	**77.7**
Median Age at RIP	**72**	73	76	68	78	**80**
Age Groups						
31-40	**1**	0	0	0	0	**0**
41-50	**0**	1	0	0	1	**0**
51-60	**5**	1	0	1	0	**3**
61-70	**3**	3	2	4	1	**2**
71-80	**4**	6	4	0	7	**3**
81-90	**7**	2	2	2	5	**3**
91-100	**0**	2	0	1	1	**4**

Gender

	IPU	IPU %	Community	Community %
Period	Male	Female	Male	Female
2024	**10 (50%)**	**10 (50%)**	**9 (60%)**	**6 (40%)**
2022	10 (67%)	5 (33%)	12 (80%)	3 (20%)
2021	3 (37.5%)	5 (62.5%)	3 (37.5%)	5 (62.5%)

Ethnicity

Ethnicity	IPU 2024	IPU 2022	Community 2024	Community 2022
White British	**14 (70%)**	10 (67%)	**7 (47%)**	11 (73%)
White Irish	**1 (5%)**	1 (7%)	**1 (7%)**	1 (6%)
White Other	**1 (5%)**	2 (13%)	**0**	0
Asian Indian	**1 (5%)**	0	**0**	0
Asian Other	**0**	0	**1 (7%)**	0
Black Caribbean	**1 (5%)**	0	**0**	0
Black African	**1 (5%)**	0	**0**	0
Mixed White and Black Caribbean	**0**	0	**1 (7%)**	0
Mixed Other	**0**	0	**1 (7%)**	0
Other	**0**	0	**1 (7%)**	0
Not stated	**1 (5%)**	2 (13%)	**3 (20%)**	3 (20%)

Diagnosis

Diagnosis	IPU	IPU %	Community	Community %
Cancer 2024	**19/20**	**95%**	**12/15**	**80%**
Cancer 2022	12/15	86%	12/15	80%
Cancer 2021	7/8	87.5%	8/8	100%
Non-cancer 2024	**1/20**	**5%**	**3/15**	**20%**
Non-cancer 2022	2/15	14%	3/15	20%
Non-cancer 2021	1/8	12.5%	0/8	0%

Did the patient have any of the following?

Diagnosis	IPU 2024		IPU 2022		Community 2024	Community 2022
	YES	NO	YES	NO		
Dementia	**0**	**20 (100%)**	3 (20%)	12 (80%)	**Yes 1 (7%) no 14 (93%)**	Yes 3 (20%) no 12 (80%)
Learning Disability	**0**	**20 (100%)**	0	15 (100%)	**Yes 0 (0%), no 15 (100%)**	Yes 1 (6%) no 14 (94%)
Other mental health diagnosis	**3 (15%)**	**17 (85%)**	0	15 (100%)	**Yes 2 (13%) no (87%)**	Yes 1 (6%) no 14 (94%)

Length of stay (LoS) and Days Between Start of Referral and RIP

	IPU (LoS) 2024	**IPU** (LoS) 2022	**IPU** (LoS) 2021	**Community** (Referral to RIP) 2021	**Community (ref to RIP) 2022**	**Community (ref to RIP) 2024**
Range	**0-44 days**	0-54 days	3-20 days	25-221 days	1-370 days	**3-399 days**
Average No of Days	**7.6 days**	10.5 days	9 days	85 days	63 days	**97.5 days**
Median No of Days	**4 days**	6 days	8 days	65 days	16 days	**36 days**

Days Between Documented evidence of recognition that patient might die and RIP

	IPU 2024	**IPU** 2022	**Community** 2024
Range	**0-42 days**	0-5 days	**2-8 days**
Average No of Days	**4.3 days**	2 days	**5.3 days**
Median No of Days	**1 day**	1 day	**6 days**

Recognition of Dying Phase Recording vs Phase of Illness recording

IPU 2024								
Patient	LOS (in days)	Possible RIP recognised within how many days of RIP?	Dying phase first recorded within how many days of RIP?	Dying phase first recorded by whom?	Dying phase last recorded within how many days of RIP?	Dying phase last recorded by whom?	Last phase of illness recorded within how many days of RIP?	Last phase of illness recorded by whom?
One	0	0	0	Physician Associate	0	Physician Associate	0	Physician Associate
Two	1	0	0	Doctor	0	Doctor	0	Doctor
Three	3	2	2	Doctor	2	Doctor	2	Doctor
Four	21	12	1	Nurse	1	Nurse	1	Nurse
Five	44	42	4	Physician Associate	2	Doctor	2	Doctor
Six	0	0	0	Nurse	0	Nurse	0	Nurse
Seven	2	2	2	Doctor	2	Nurse	2	Nurse
Eight	0	0	0	Nurse	0	Nurse	0	Nurse
Nine	7	1	1	Physician Associate	1	Physician Associate	1	Physician Associate
Ten	3	1	1	Doctor	0	Doctor	0	Doctor
Eleven	10	1	1	Doctor	1	Doctor	1	Doctor
Twelve	7	3	3	Physician Associate	2	Doctor	2	Doctor
Thirteen	2	2	1	Physician Associate	1	Physician Associate	1	Physician Associate
Fourteen	21	8	2	Physician Associate	0	Doctor	0	Doctor
Fifteen	5	3	3	Physician Associate	0	Nurse	0	Nurse
Sixteen	2	2	NR	NR	NR	NR	0	Consultant
Seventeen	9	1	NR	NR	NR	NR	0	Doctor
Eighteen	6	NR	NR	NR	NR	NR	2	Doctor
Nineteen	5	1	1	Nurse	1	Nurse	1	Nurse
Twenty	3	1	1	Physician Associate	0	Nurse	0	Nurse

- Average Length of stay is 7.6 days
- On average, documentation that the patient might die was recorded 4.3days before death.
- On average, the dying phase was first recorded within 1.35 days of death (for the patients that had a dying phase recorded)

Commented [NC1]: Can I double check the average LOS - here mentioned as 6 days (with range 0-21 days) but in the results two boxes above range is 0-44 and average 7.6??

Commented [AR2R1]: I agree Naomi - over to you Jonathan

Commented [JC3R1]: Very sorry - I completed the page seven table after finishing the rest of the report and I was studying the raw data and EMIS records for filling it in and I misread the month of admission for patient no. 5, although I had previously input the correct figures for my databases from which I drew the figures for the other table above. I have corrected the page seven table now. Also, regarding the averages, I think that no. 18 should really be excluded from the averages calculation for the lengths of time between documented recognition and RIP because it is not recorded that there was documented evidence that patient 18 might RIP, so I have adjusted that average accordingly in both tables (that average is calculated by dividing the total number of days by 19 instead of 20).

Use of “Care at the end of life” section on electronic patient record (EMIS)

Use of EOLC template	IPU 2024	IPU 2022	Community 2024	Community 2022
Yes	**12/20 (60%)**	9/15 (60%)	**2/15 (13%)**	4/14 (29%)
No	**8/20 (40%)**	6/15 (40%)	**13/15 (87%)**	10/14 (71%)

Possibility of dying discussed with patient?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Forgetful	No – Other reason	No – No reason	NR	*Compliance*
2024 IPU	11 (92%)	6	2	0	0	0	1 (8%)	0	92%
2024 CPCT	5 (100%)	5	0	0	1*	0	0	4	100%
2022 IPU	5 (100%)	5	4	0	0	0	0	1	100%

*CPCT #3

Possibility of dying discussed with nominated person(s)?	Yes	No – Contact unsuccessful/No nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	NR	*Compliance*
2024 IPU	20 (100%)	0	0	0	0	0	0	100%
2024 CPCT	11 (100%)	0	0	0	0	0	4	100%
2022 IPU	14 (93%)	0	0	0	0	1 (7%)	0	93%

Documented evidence that nominated person was notified that the patient was about to die?	Yes	No – Contact unsuccessful/No nom	No - Insufficient time	No – Nom already present	No – Sudden deterioration at end	No – No reason	NR	*Compliance*
2024 IPU	19 (100%)	0	1	0	0	0	0	100%
2024 CPCT	8 (100%)	0	0	1	1*	0	5	100%
2022 IPU	13 (87%)	0	2	0	0	0	0	100%

*CPCT #4 - Sudden deterioration at end

Individualised Care Planning

1. Documented evidence that patient participated in individualised care planning prior to realisation they might die, and had their wishes recorded?	Yes – Prior to admission	Yes – during final admission	Yes – Prior to death	No advance care plan	NA	NR	*Compliance*
2024 IPU	**19 (95%)**	**1 (5%)**	**0**	**0**	**0**	**0**	**100%**
2022 IPU	9 (75%)	2 (17%)	0	1 (8%)	2	1	92%
2021 IPU	8 (100%)	0	0	0	0	0	100%
2021 CPCT	7 (88%)	0	0	1 (13%)	0	0	88%
2022 CPCT	14 (100%)	NA	0	0	0	0	100%
2024 CPCT	**12 (86%)**	**0**	**1 (7%)**	**1 (7%)**	**1**	**0**	**93%**

2. Was there documented evidence of the preferred place of death (PPD) as indicated by the patient?	Yes	No	Not recorded	*Compliance*
2024 IPU	19 (95%)	1 (5%)	0	95%
2022 IPU	10 (71%)	4 (29%)	1	71%
2022 CPCT	14/14 (100%)	0/14 (0%)	0	100%
2024 CPCT	13 (87%)	2 (13%)	0	87%

3. Is there documented evidence that the patient who was dying had an individualised care plan addressing their end of life care needs?	Yes	No	Not recorded	*Compliance*
2024 IPU	**20 (100%)**	**0**	**0**	**100%**
2022 IPU	13 (87%)	2 (13%)	0	87%
2021 IPU	8 (100%)	0	0	100%
2021 CPCT	7 (88%)	1 (13%)	0	88%
2022 CPCT	13/14 (93%)	1/14 (7%)	0	93%
2024 CPCT	**13/15 (87%)**	**2/15 (13%)**	**0**	**87%**

4. Is there documented evidence that the patient and their individualised care plan were reviewed regularly? 2024 IPU (Based on the 19 'yes' answers to question 3). 2024 CPCT (Based on the 13 'yes' answers to question 3)	Yes	Patient died before review was necessary	No	NR	*Compliance*
2024 IPU	**12 (63%)**	**7 (37%)**	**0**	**0**	**100%**
2022 IPU	5 (38%)	8 (62%)	0	0	100%
2021 IPU	8 (100%)	0	0	0	100%
2021 CPCT	7 (88%)	0	1 (13%)	0	88%
2022 CPCT	-	-	-	14	-
2024 CPCT	**3 (25%)**	**8 (67%)**	**1 (8%)**	**1**	**92%**

5. Is there documented evidence that the patient was involved in discussing the individualised plan of care? 2024 IPU (Based on the 19 'yes' answers to question 3). 2024 CPCT (Based on the 13 'yes' answers to question 3)	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Pt non-verbal	No – No reason	NR	*Compliance*
2024 IPU	**13 (100%)**	**4**	**2**	**0**	**0**	**0**	**0**	**100%**
2022 IPU	6 (100%)	4	3	0	0	0	0	100%
2021 IPU	8 (100%)	0	0	0	0	0	0	100%
2021 CPCT	7 (88%)	0	0	0	0	1 (13%)	0	88%
2022 CPCT	6 (75%)	1	3	0	0	2 (25%)	2	75%
2024 CPCT	**8 (100%)**	**3**	**0**	**0**	**1***	**0 (0%)**	**1**	**100%**

*CPCT #4

6. Is there documented evidence that the nominated person was involved in discussing the individualised plan of care?	Yes	No – Could not contact/no nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	NR	*Compliance*
2024 IPU (Based on the 19 'yes' answers to question 3).	**19 (100%)**	**0**	**0**	**0**	**0**	**0**	**0**	**100%**
2022 IPU	12 (80%)	0	0	0	0	0	1	80%
2021 IPU	8 (100%)	0	0	0	0	0	0	100%
2021 CPCT	7 (88%)	0	0	0	0	1 (12%)	0	88%
2022 CPCT	-	-	-	-	-	-	14	-
2024 CPCT (Based on the 13 'yes' answers to question 3)	**13 (100%)**	**0**	**0**	**0**	**0**	**0**	**0**	**100%**

Overall compliance - Was the care plan discussed with both the patient and the people important to them?	Yes	No
2024 IPU	19 (100%)	0
2022 IPU	12 (80%)	3 (20%)
2021 IPU	8 (100%)	0
2021 CPCT	7 (88%)	1 (12%)
2022 CPCT	N/R	N/R
2024 CPCT	13 (100%)	0

- In 2024 on the IPU 19 of the 20 patients had documented evidence of a care plan and evidence that this had been discussed with **both** the patient (where the patient was able to discuss it) and with their nominated person. In 2024 on the CPCT 13 of the 15 patients had documented evidence of a care plan and evidence that this had been discussed with **both** the patient (where the patient was able to discuss it) and with their nominated person.

7. Is there documented evidence of the following needs:

IPU	IPU – Numbers 2024			IPU - % 2024		IPU – Numbers 2022			IPU - % 2022	
Is there documented evidence of an assessment of the following needs?	Yes	No	NA	Yes	No	Yes	No	NR	Yes	No
Agitation/Delirium	20	0	0	**100**	0	14	0	1	**100**	0
Dyspnoea/ breathing difficulty	20	0	0	**100**	0	14	0	1	**100**	0
Nausea/ vomiting	20	0	0	**100**	0	14	0	1	**100**	0
Pain	20	0	0	**100**	0	14	0	1	**100**	0
Noisy breathing/ death rattle	19	0	1	**100**	0	13	1	1	**93**	7
Bladder function	20	0	0	**100**	0	14	0	1	**100**	0
Bowel function	20	0	0	**100**	0	14	0	1	**100**	0
Pressure areas	20	0	0	**100**	0	14	0	1	**100**	0
Hygiene requirements	20	0	0	**100**	0	14	0	1	**100**	0
Mouth care	20	0	0	**100**	0	14	0	1	**100**	0

CPCT	CPCT – Numbers 2024				CPCT - % 2024	
Is there documented evidence of an assessment of the following needs?	Yes	No	NA	NR	Yes	No
Agitation/Delirium	8	3	0	0	**73**	27
Dyspnoea/ breathing difficulty	14	0	0	1	**100**	0
Nausea/ vomiting	11	3	0	0	**79**	21
Pain	14	0	0	1	**100**	0
Noisy breathing/ death rattle	6	4	3	2	**60**	40
Bladder function	14	0	0	1	**100**	0
Bowel function	14	0	0	1	**100**	0
Pressure areas	6	6	0	3	**50**	50
Hygiene requirements	8	3	0	4	**73**	27
Mouth care	10	4	0	1	**71**	29

Is there documented evidence of an assessment of the following needs? IPU	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Other reason	No – No reason	*NR*	*Compliance*
Anxiety/Distress 2024	19 (100%)	1	0	0	0	0	*0*	*100%*
Anxiety/Distress 2022	8 (100%)	5	1	0	0	0	*1*	*100%*
Emotional/Psychological 2024	16 (100%)	3	1	0	0	0	*0*	*100%*
Emotional/Psychological 2022	8 (100%)	4	2	0	0	0	*1*	*100%*
Spiritual/ Religious/ Cultural needs 2024	19 (95%)	0	0	0	0	1 (5%)	*0*	*95%*
Spiritual/ Religious/ Cultural needs 2022	12 (86%)	0	0	0	1 (7%)	1 (7%)	*1*	*86%*
Social and practical needs 2024	18 (100%)	2	0	0	0	0	*0*	*100%*
Social and practical needs 2022	10 (100%)	3	1	0	0	0	*1*	*100%*

Is there documented evidence of an assessment of the following needs? CPCT	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Pt Non-Verbal	No – Other reason	No – No reason	*NR*	*Compliance*
Anxiety/Distress 2024	8 (89%)	5	1	0	0	0	1 (11%)	*0*	*89%*
Emotional/Psychological 2024	10 (91%)	2	1	0	1	0	1 (9%)	*0*	*91%*
Spiritual/ Religious/ Cultural needs 2024	11 (73%)	0	0	0	0	1* (7%)	3 (20%)	*0*	*73%*
Social and practical needs 2024	15 (100%)	0	0	0	0	0	0	*0*	*100%*

*CPCT #2 'Other' reason is not specified on the form, so treated as non-compliant for the purposes of these figures

Care Planning of Treatments

IPU	IPU – Numbers 2024				IPU - % Compliance 2024	IPU – Numbers 2022				IPU - % Compliance 2022
8. Is there documented evidence of an assessment of the following needs?	Yes	No	NA	NR		Yes	No	NA	NR	
Routine recording of vital signs	2	0	18	0	**100%**	2	0	12	1	**100%**
Blood sugar monitoring	4	0	16	0	**100%**	2	1	11	1	**67%**
The administration of oxygen	12	0	8	0	**100%**	5	0	9	1	**100%**
The administration of antibiotics	5	0	15	0	**100%**	2	0	12	1	**100%**
Routine blood tests	2	0	18	0	**100%**	2	0	12	1	**100%**
Other medication	11	0	8	1	**100%**	7	1	5	2	**88%**

2024 CPCT	CPCT - Numbers				CPCT - % Compliance
8. Is there documented evidence of an assessment of the following needs?	Yes	No	NA	NR	
Routine recording of vital signs	0	0	14	1	**-**
Blood sugar monitoring	0	0	13	2	**-**
The administration of oxygen	1	0	13	1	**100%**
The administration of antibiotics	2	0	12	1	**100%**
Routine blood tests	0	0	14	1	**-**
Other medication	2	0	11	2	**100%**

Symptom Management

9. Is there documented evidence that anticipatory medication was prescribed for symptoms likely to occur in the last days of life?	Yes, anticipatory medication prescribed but not used	Yes, anticipatory medication prescribed and administered	No	N/A	Not recorded
2024 IPU	20 (100%)		0	0	0
2022 IPU	0	15 (100%)	0	0	0
2021 IPU	8 (100%)		0	0	0
2021 CPCT	8 (100%)		0	0	0
2022 CPCT	13 (100%)		0	0	2 (13%)
2024 CPCT	13 (93%)		1 (7%)	0	1

10. Is there documented evidence that an indication for the use of the medication was included in the prescription?	Yes – For all medications	Yes – For some medications	No	Not recorded	*Compliance*
2024 IPU	**20 (100%)**	**0**	**0**	**0**	***100%***
2022 IPU	15 (100%)	0	0	0	*100%*
2021 IPU	8 (100%)	0	0	0	*100%*
2021 CPCT	8 (100%)	0	0	0	*100%*
2022 CPCT	12 (100%)	0	0	0	*100%*
2024 CPCT	**13 (100%)**	**0**	**0**	**2**	***100%***

11. Is there documented evidence that a discussion about the use of anticipatory medication was undertaken with the patient?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Fatigued	No – Pt Non Verbal	No – Other reason	No – No reason	NR	*Compliance*
2024 IPU	8 (80%)	5	3	0	1	0	0	2 (20%)	1	*80%*
2022 IPU	4 (67%)	5	4	0	0	0	0	2 (33%)	0	*67%*
2024 CPCT	2 (50%)	6	2	0	0	1	1* (25%)	1 (25%)	2	*50%*

*CPCT # 3 ‘Other’ reason not specified so treated as not compliant

12. Is there documented evidence that a discussion about the use of anticipatory medicine was undertaken with the nominated person(s)?	Yes	No – Could not contact/no nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	NR	*Compliance*
2024 IPU	18 (95%)	0	0	0	0	1 (5%)	1	*95%*
2022 IPU	9 (69%)	0	0	0	0	4 (31%)	2	*69%*
2024 CPCT	11 (85%)	0	0	0	1* (8%)	1 (8%)	2	*85%*

*CPCT#5 Other reason not specified – treated as non-compliant

Commented [NC4]: Can I check whether the compliance for the IPU should not be 90% as 2 people did not have a reason given for non discussion (2/20) and similarly for the community team should this not be only 2/15 non compliant?

Commented [AR5R4]: IPU compliance is based on Yes/(No - Other reason not recorded + No - No reason) so IPU 2024 would be 8/10= 80% & CPCT 2024 would be 2/4=50%

13. Is there documented evidence that the possibility of drowsiness, if likely as a result of prescribed medications, was discussed with the patient?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No - Fatigued	No – Patient non-verbal	No – Other reason	No – No reason	NA	NR	*Compliance*
2024 IPU	4 (44%)	5	3	0	1	0	0	5 (56%)	2	0	*44%*
2022 IPU	4 (67%)	5	4	0	0	0	0	2 (33%)	0	0	*67%*
2024 CPCT	1 (20%)	5	2	0	0	1	0	4 (80%)	1	1	*20%*

Commented [NC6]: Similar to above, should IPU compliance not be 75% as 5/20 did not have a valid reason as to why discussion had not taken place?
And CPCT compliance be 9/15?

Commented [AR7R6]: 2024 IPU would be 4/9-44% and 2024 CPCT would 1 /5 = 20%

Commented [JC8R6]: Sorry, yes, I forgot to update the compliance figure to 44% after we discussed that the fatigued patient did not count as either a yes or a no regarding compliance. It's amended now.

14. Is there documented evidence the possibility of drowsiness, if likely as a result of prescribed medications, was discussed with the nominated person?	Yes	No – Could not contact/no nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	NA	NR	*Compliance*
2024 IPU	10 (56%)	0	0	0	0	8 (44%)	2	0	*56%*
2022 IPU	6 (40%)	0	0	0	0	9 (60%)	0	0	*40%*
2024 CPCT	2 (20%)	0	0	0	0	8 (80%)	3	2	*20%*

15. Is there documented evidence that the patient had a continual infusion of medications e.g. via syringe pump?	Yes	No	Not Applicable	Not recorded
2024 IPU	**16 (80%)**	**4 (20%)**	**0**	**0**
2022 IPU	12 (80%)	3 (20%)	0	0
2021 IPU	8 (100%)	0	0	0
2021 CPCT	8 (100%)	0	0	0
2022 CPCT	2 (67%)	1(33%)	0	12
2024 CPCT	**10 (71%)**	**4 (29%)**	**0**	**1**

16. Is there evidence of a documented discussion with patient on the need for a syringe pump?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Other reason	No – No reason	NA	NR	*Compliance*
2024 IPU (Relates to the 16 'Yes' answers for question 15)	3 (75%)	5	3	0	0	1 (25%)	4*	0	*75%*
2022 IPU	5 (100%)	3	3	0	0	0	1	0	*100%*
2024 CPCT (Relates to the 10 'Yes' answers for question 15)	1 (100%)	7	2	0	0	0	0	0	*100%*

*All four patients admitted with syringe drivers already in place

17. Is there evidence of a documented discussion with the nominated person on the need for a syringe pump?	Yes	No – Could not contact/no nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	N/A	NR	*Compliance*
2024 IPU (Relates to the 16 'Yes' answers for question 15)	13 (100%)	0	0	0	0	0	3*	0	*100%*
2022 IPU	9 (82%)	0	0	0	0	2 (18%)	1	0	*82%*
2024 CPCT (Relates to the 10 'Yes' answers for question 15)	9 (90%)	0	0	0	0	1 (10%)	5	0	*90%*

*All three patients admitted with syringe drivers already in place

Drinking and Assisted Hydration

18. Is there documented evidence that the patient's hydration status was assessed daily once the dying phase was recognised?	Yes	No	*Not recorded*	*Compliance*
IPU 2024	**20 (100%)**	**0**	***0***	***100%***
IPU 2022	15 (100%)	0	*0*	*100%*
IPU 2021	8 (100%)	0	*0*	*100%*
CPCT 2021	3 (37.5%)	6 (62.5%)	*0*	*37.5%*
CPCT 2022	--	--	*15*	*na*
CPCT 2024	**10 (83%)**	**2 (17%)**	***3***	***83%***

19. Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the patient once the dying phase was recognised?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Fatigued	No – Other reason	No – No reason	N/A	NR	*Compliance*
IPU 2024	**1 (33%)**	**7**	**3**	**0**	**2**	**1* (33%)**	**1 (33%)**	**5**	**0**	***33%***
IPU 2022	2 (40%)	5	5	0	0	0	3 (60%)	0	0	*40%*
IPU 2021	0 (0%)	0	0	0	0	0	8 (100%)	0	0	*0%*
CPCT 2021	0 (0%)	0	0	0	0	0	8 (100%)	0	0	*0%*
CPCT 2022	0	0	0	0	0	0	15 (100%)	0	0	*0%*
CPCT 2024	**1 (100%)**	**8**	**2**	**0**	**0**	**0**	**0**	**2**	**2**	***100%***

*IPU #16 – 'Other' reason not specified. Treated as non-compliant

20. Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the nominated person once the dying phase was recognised?	Yes	No – Could not contact/no nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	N/A	NR	*Compliance*
IPU 2024	12 (86%)	0	0	0	0	2 (14%)	6	0	*86%*
IPU 2022	6 (43%)	0	0	0	0	8 (57%)	1	2	*43%*
IPU 2021	0 (0%)	0	0	0	0	8 (100%)	0	0	*0%*
CPCT 2021	0 (0%)	0	0	0	0	8 (100%)	0	0	*0%*
CPCT 2022	5 (33%)	0	0	0	0	10 (66%)	0	0	*33%*
CPCT 2024	9 (100%)	0	0	0	0	0	4	2	*100%*

21. Is there documented evidence that the patient was supported to drink as long as they were able and wished to do so?	Yes	No	Not Applicable	Not recorded	*Compliance*
IPU 2024	19 (100%)	0	1	0	*100%*
IPU 2022	15 (100%)	0	0	0	*100%*
CPCT 2024	10 (100%)	0	3	2	*100%*

Eating and Assisted nutrition

22. Is there documented evidence that the patient's nutrition status was reviewed regularly once the dying phase was recognised?	Yes	No	*Not recorded*	*Compliance*
2024 IPU	19 (95%)	1 (5%)	*0*	*95%*
2022 IPU	15 (100%)	0	*0*	*100%*
2024 CPCT	10 (83%)	2 (17%)	*3*	*83%*

23. Is there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the patient once the dying phase was recognised?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Pt fatigued/ delirium	No – Other reason	No – No reason	*N/A*	*NR*	*Compliance*
2024 IPU	1 (33%)	8	3	0	1	0	2 (67%)	*5*	*0*	*33%*
2022 IPU	2 (50%)	7	4	0	0	0	2 (50%)	*0*	*0*	*50%*
2024 CPCT	1 (100%)	7	3	0	0	0	0	*2*	*2*	*100%*

24. Is there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the nominated person once the dying phase was recognised?	Yes	No – Could not contact/no nom	No – Pt did not consent	No – IMCA unavailable	No – Other reason	No – No reason	*N/A*	*NR*	*Compliance*
2024 IPU	6 (75%)	0	0	0	0	2 (25%)	*12*	*0*	*75%*
2022 IPU	5 (36%)	0	0	0	0	9 (64%)	*1*	*0*	*36%*
2024 CPCT	5 (83%)	0	0	0	0	1 (17%)	*7*	*2*	*83%*

25. Is there documented evidence that the patient was supported to eat as long as they were able to and wished to do so?	Yes	No	*NA*	*Not recorded*	*Compliance*
2024 IPU	19 (100%)	0	*1*	*0*	*100%*
2022 IPU	14 (100%)	0	*1*	*0*	*100%*
2024 CPCT	9 (90%)	1 (10%)	*3*	*2*	*90%*

Involvement in Decision Making

1. Is there documented evidence about the extent to which the patient wished to be involved in decisions about their care?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Pt non-verbal	No – Other reason	No – No reason	*N/A*	*NR*	*Compliance*
2024 IPU	3 (100%)	4	1	0	0	0	0	*0*	*12*	*100%*
2022 IPU	5 (83%)	5	3	0	0	0	1 (17%)	*0*	*1*	*83%*
2024 CPCT	2 (100%)	1	0	0	1	0	0	*0*	*11*	*100%*

2. Is there documented evidence that the dying person had their capacity assessed to be involved in their end of life care planning?	Yes	No – Pt semi-conscious	No – Pt lacked capacity to understand	No – Pt did not wish to discuss	No – Other reason	No – No reason	*Mental Incapacity not suspected*	*NR*	*Compliance*
2024 IPU	2 (100%)	4	1	0	0	0	*1*	*12*	*100%*
2022 IPU	10 (91%)	1	1	0	0	1 (9%)	*0*	*2*	*91%*
2024 CPCT	3 (100%)	1	0	0	0	0	*0*	*11*	*100%*

The absence of documentation does not mean that discussions were *not* had or care *not* given, however if an action is not documented then it has to be considered to have not been carried out.

Discussion

NICE Quality Standards

IPU Deaths
6 out of the 8 NICE Quality standards were met for 100% of those who died on the IPU in 2024 (c.f. 4 out of the 8 in 2022), namely:-

- daily monitoring of signs and symptoms
- having an individualised care plan
- discussing the care plan with both the patient and people important to them
- anticipatory medications prescribed
- individualised indications for anticipatory medications prescribed, dosage and route of administration of these medications.
- daily monitoring of patient's hydration status

One quality standard was not met 100% of the time : -
- Discussion of the risks and benefits of hydration options after the dying phase is recognised was only recorded for 33% of patients and 86% of nominated people (c.f. 40% of patients and 43% of nominated people in 2022. This standard had 0% compliance in 2021).

Data was not specifically captured to allow comment on one quality standard – "100% dying adults in the last days of life have the care plan followed" though there was no indication that patient care plans were not followed.

Community deaths

3 of the 8 NICE quality standards were met for 100% of those who died under the care of the CPCT in 2024, namely:-
- discussing the care plan with both the patient and people important to them
- individualised indications for anticipatory medications prescribed, dosage and route of administration of these medications.
- discussion of the risks and benefits of hydration options after the dying phase is recognised.

Regarding the remaining four quality standards: -

- daily monitoring of signs and symptoms achieved 92% compliance
- Having an individualised care plan for each patient achieved just 87% compliance
- anticipatory medications prescribed achieved 93% compliance
- daily monitoring of hydration status achieved 83% compliance

As for the IPU, data was not specifically captured to allow comment on one quality standard – "100% dying adults in the last days of life have the care plan followed".

What are we doing well?

It is reassuring to see that in most areas we are **fully compliant** with the NICE recommendations for deaths occurring on the inpatient unit. Data capture for deaths in community will always be less complete than for those on the IPU, as contact is by nature more intermittent, however compliance was also very high for this group.

Areas for improvement

This audit is, as always, an audit of the documentation of care provided and discussions held rather than an audit of the care provided per se. It remains an ongoing possibility that conversations have not all been documented thereby providing an underestimation of care. Use of the End of life care template on EMIS was designed to aid a more complete capture of the care and conversations held at the end of life. Use of the template for the sample of patients audited was 60% of deaths occurring on the IPU (same as IPU 2022) and 13% of those in the community (down from 29% from CPCT 2022)

Consideration and discussion of the risks and benefits of hydration and nutrition options *once the dying phase is recognised* may be somewhat controversial. Some information is already available in an information leaflet, "What to expect in the last days of life", though this is advertised as "An information leaflet for carers and families" rather than patients per se and does not address the risks and benefits explicitly. Whilst it is hoped that conversations with patients and those important to them regarding the approaching end of life include addressing any concerns about the patient's likely reduced oral intake of food and fluids, we are not explicitly capturing these conversations. Whilst we do not want to alter practice purely to "tick a box" for an audit, if patients and those important to them have concerns of this nature we obviously want to be addressing them.

Recommendations

1. We are committed to the ongoing monitoring of the care provided at the end of life to both in patient and community patient with use of national tools to guide data capture and benchmarking. It is hoped that the national audit may extend from deaths in hospital to include hospice deaths thus allowing us to benchmark against our peers.

Action – We will continue to include audit of care at the end of life in our annual audit programme, aiming to improve the turnaround time to allow more time for embedding recommendations from the previous audit ahead of data collection for subsequent audits.

2.To specifically address the lack of documentation regarding discussions around the risks and benefits of hydration (and nutrition) options at the end of life.

Action – To raise this issue with the Hospice patient user group in order to assess importance to patients and those important to them and to consider the best manner in which to address it. To discuss with nursing colleagues whether this could be included in IPU nursing care plan.

3. Promote usage of the EOLC template when the patient is entering the dying phase

Action – To reanalyse the data to assess if use of the template has improved data capture (as it did in previous years).

Analysing the data as to whether use of the EOLC template improved documentation of discussion of the risks/ benefits of hydration options with patient and NOK did **not** show a benefit. Of the 12 (60%) of IPU deaths in which an EOLC template *was* completed, hydration was never documented as being discussed with the patient (0%); it was discussed with 58% of nominated persons. Of the 40% of cases in which the EOLC template was *not* used, hydration options were discussed with one patient (12.5%) and 42% of nominated persons. This is only one aspect of the documentation but was chosen for review as compliance was below 100% for this quality standard.
To aim to monitor use of the template in real time in order to feedback to medical and CPCT a monthly usage for three months prior to re-auditing EOLC.