Proposal for collection of data

Background

- DoH data suggests approx. 30% of adult in-patients (England & Wales) are in their last year of life
- Scotland: 24% of intensive care survivors are readmitted to hospital within 90 days of discharge (re-admission relates more to long-standing co-morbidities than the severity of their acute illness)
- Wales: 1 in 5 intensive care survivors die within a year of discharge home (again a correlation with pre-admission co-morbid state, rather than severity of acute illness)
- Advance care planning:
  - Improves shared decision making
  - Increases clarity of patients' wishes and beliefs should they ever lose capacity
  - Reduces anxiety, confusion and moral distress in families and staff when dealing with severe acute illness (see above)
  - Increases the likelihood of dying patients doing so at-home/ in a hospice
- The SPICT™ Tool can screen for patients with life-limiting/life-threatening chronic disease should they ever be admitted to hospital and act as a trigger for initiating ACP discussions and the development of an individualised Treatment Escalation Plan (TEP)
- Previous Point Prevalence Audits by NoECCN have revealed variable numbers of TEPs for in-patients across NE & Cumbria (and usually <30% of in-patients)

Aims

- To determine the number of ward-based adult in-patients that meet SPICT™ criteria
- To determine the number of TEPs in place for ward-based patients and compare to the number of patients meeting SPICT™ criteria

Methods

- Point prevalence audit involving local Critical Care Outreach Teams across NoECCN, with medical support from local Directorates for Perioperative and Critical Care

For more information on SPICT see https://www.spict.org.uk/