SOUTHAMPTON MEDICAL ANTICIPATORY PLAN:

Communicating priorities of care for nursing home resident's discharged from hospital

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Background

Nursing Homes residents have multiple co-morbidities and the majority are in their last year of life, repeated hospital admission makes little difference to their outcomes. Anticipating and planning for health events is an essential component of delivering high quality, patient focussed care to this population. Communicating patient's priorities of care can be achieved via an Anticipatory Care Plan (ACP). University Hospital Southampton (UHS) is a large acute hospital with multiple health and social care interfaces; anecdotal evidence suggested scope to develop this service within the system.

Project Design

Areas of best practice were identified within the UK and examples of Anticipatory Care Plans reviewed. We conducted stake-holder analysis with semi-structured interviews to identify common themes and to evaluate current practice. Following on from this we were able to develop the Southampton Medical Anticipatory Plan (SMAP) for use within UHS.

Aim:

To develop and embed an ACP within the acute healthcare setting for nursing home residents.

University Hospital Southampton NHS Foundation Trust
Southampton General Hospital

SOUTHAMPTON MEDICAL ANTICIPATORY PLAN
SUGGESTED ACTION on PROGRESSION of ILLNESS
Advice of health care professionals for use in future best interest decisions. Based on PEACE from GSTT.
This form is advisory only and may not be applicable if the resident's wishes or clinical condition changes or a situation arises which is not anticipated. If concerns please contact the named Physician or GP for further advice.

PATIENT DETAILS
Patient Name: MR 22222 TEST
Address: 9 Clydesdale Way, Totton, Southampton, Hampshire. SO40 8HZ
Hospital Number: 3028973
Date of Birth: 01/01/1900
NHS Number:
Sex: Male
Phone No:
GP: Dr M General
Care Home:
Consultant:
Clinical Case Manager:

Patients wishes including Preferred Place of Care

Summary of medical problems. (Please also refer to attached hospital discharge letter)

	Possible Developments specific to the resident	Action Category	Comments including Patient's views. *Please also see supplementary notes for care home staff (attached)*
1	Lower respiratory tract infection/UTI		
2	Fall and limb pain	See attached guidance	
3	Poor oral intake		
4	Signs of possible stroke or coma		
5	Person has no signs of life	Respectful Care	Patient has a signed DNACPR
6	Unexpected acute medical problem/deterioration		
7			
8			
9			

Summary of suggested action categories:
Intensive: Transfer to hospital for treatment if appropriate. Critical care, intubation and ventilation should be considered.
Hospital: Transfer to hospital for treatment if appropriate but not for critical care, intubation and ventilation.
Home: Treatment medication and comfort measures within care home with support from GP. Admission to hospital to be avoided unless comfort measures fail.
Comfort: Palliative Medication by subcutaneous, oral or per rectal route, positioning, wound care and other measures to relieve suffering. Admission to hospital to be avoided unless comfort measures fail.

Does the person have a unified Do Not Attempt Resuscitation order in place?

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SMAP developed.

- Individualised electronic document completed in hospital.
- Facilitates communication and documents patients priorities care.
- Shared across care providers, patient and the nursing home.

Engagement clinical teams.

- SMAP piloted within Medicine for Older People Department.
- Locality based working: patients always looked after by same clinical team.
- Clinical Case Manager for each team allocated new role of completing SMAP.
- Education on the anticipatory care planning and use of SMAP.

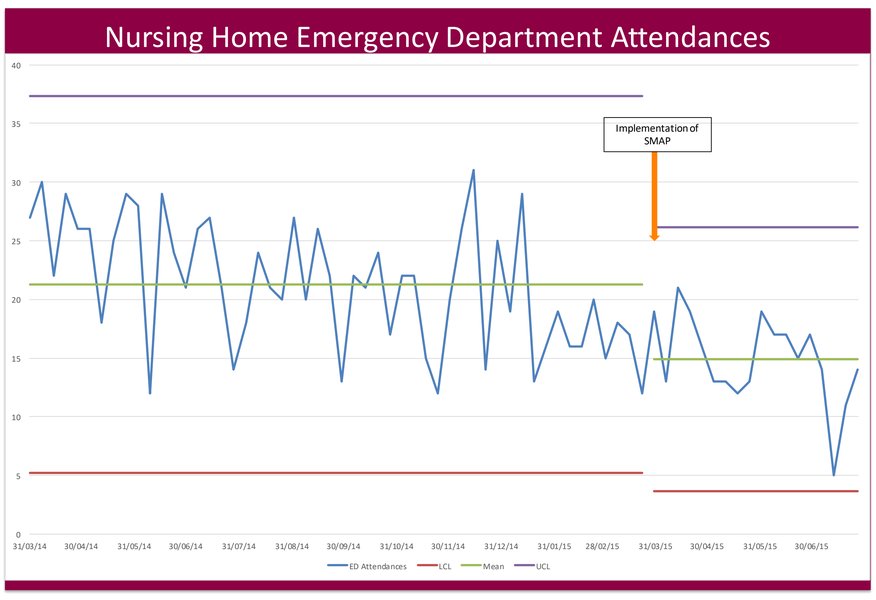
Implementation

Iterative process over an initial pilot period of 3 months.
Readmissions reviewed to ensure learning and process adapted to reflect this.
Follow up visits or phone calls to care home carried out to reinforce understanding and education.
Handbook and FAQ for nursing homes developed.
Qualitative feedback obtained from 13 nursing homes, used to improve SMAP process.

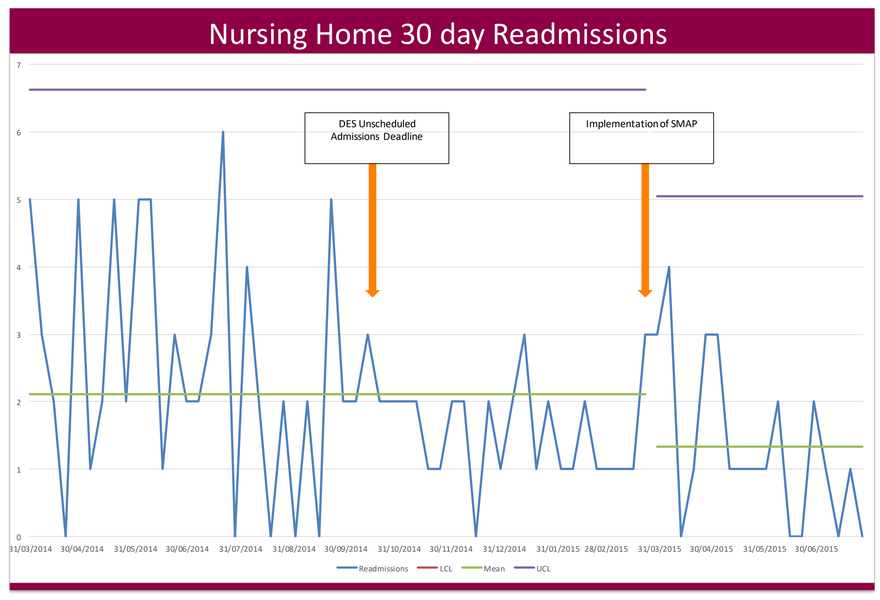
Sustainability

Inter –disciplinary working group established to monitor and evaluate outcomes to continually improve process.
Clinical Case Managers: Engaged, enthusiastic and empowered.
Triangulation with care home, Clinical Commissioning Group and other service providers such as South Central Ambulance Service.
Trust Transformation team plans to facilitate wider dissemination and embed within UHS.

Nursing Home Emergency Department Attendances



Nursing Home 30 day Readmissions



Outcomes and next steps.

- Anticipatory care planning can be successfully undertaken in hospital and is a cost effective, patient centred innovation to drive quality.
- SMAP has reduced 30 day readmissions for Nursing Home residents and contributed to a reduction in Emergency Department Attendances.
- We will be widening dissemination of SMAP too other departments such as General Medicine and Stroke.
- Future plans for pro-active approach offering an out-reach service to nursing homes, taking the service to the patient.
- SMAP can be easily adapted and already has been within the NHS by several local acute hospitals.