

# IMPROVING CARE IN THE LAST YEARS OF LIFE ON SALLY SHERMAN WARD

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## Background:

Demographic trends are changing the modern experience of death and dying. Increasingly, this involves protracted decline due to progressive chronic comorbidity and age related frailty, including **dementia**. The changing character of mortality poses singular challenges: for personal and social adaptation to an uncertain but negatively anticipated future, for social and economic management of scarce health care resources.

Around 500,000 people die in England each year. 30% of those over the age of 60 will die with dementia (Brayne et al 2006). 70% prefer to die at home (Gomes *et al* (2012) BUT in dementia: Only just over 20% die at home. 20% die in Residential Care. 56% die in hospital. Each spends an average of 34 days in hospital in their final year of life. More than 50% have between 2 and 5 admissions in their last year of life.

People with dementia are:

- more likely to die in the acute hospital
- less likely to receive hospice or palliative care
- less likely to have their spiritual needs considered when they die

(Sampson et al 2006)

54% of complaints in acute hospitals relate to care of the dying/bereavement care (Healthcare Commission 2007)

## Project aim:

The project we worked on was located on Sally Sherman ward, a continuing care ward for patients with dementia. We wanted to involve carers and families in thinking ahead for the future care of their loved ones. We aimed to draw up an advance care plan for all Sally Sherman patients within six months of the start of the project in July 2014.

## Aim:

**100% of Sally Sherman ward inpatients to have the benefit of advance care planning**

## What is advance care planning (ACP)?

ACP is a voluntary process of discussion and review to help an individual to anticipate their preferences for future care in the event they lose capacity.

NICE Guidance recommends that people with dementia should have the opportunity to discuss and make decisions about their future care while they have capacity. Without a care plan:

- 1/Families may not be adequately prepared for decisions that need to be made in the last weeks or days of life
- 2/Patients may not receive the best evidence based care in their last years, weeks and days.
- 3/Patients may inappropriately be admitted on an emergency basis to the acute trust
- 4/Patients may not be prescribed the right medication regimen for their situation

## Methods and outcomes:

Having established drivers for the project we set about running a series of PDSA cycles. One example was the ACP meeting held with a relative on 28/7/14. We learnt from this cycle to invest more preparation before meetings. Subsequently documentation and procedures were agreed including a script for meetings, addition of a chairperson, agreed recommendations to medication before the meeting. We also arranged to see family immediately after meeting for feedback/support.

**There was clear benefit from this work and we are incorporating it into the usual ward processes.**

